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PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____ PHONE _____

REFERRING DOCTOR

DOCTOR NAME _____ PRACTICE NAME _____ PHONE _____

Circle tooth number(s) for extraction / implant

UPPER (PERMANENT)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

LOWER (PERMANENT)

UPPER (PRIMARY / PEDIATRIC)

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

LOWER (PRIMARY / PEDIATRIC)

REASON FOR REFERRAL

- | | |
|--|--|
| <input type="checkbox"/> Extraction | <input type="checkbox"/> Bone Grafting |
| <input type="checkbox"/> Implant Consultation | <input type="checkbox"/> All-on-X / Full Arch Implants |
| <input type="checkbox"/> Exposure of Impacted Tooth | <input type="checkbox"/> Sinus Lift / Augmentation |
| <input type="checkbox"/> Oral Pathology / Biopsy | <input type="checkbox"/> TMJ / Facial Pain |
| <input type="checkbox"/> Corrective Jaw Surgery | <input type="checkbox"/> Facial Trauma |
| <input type="checkbox"/> Pre-Prosthetic Surgery / Tori Removal | <input type="checkbox"/> Other: _____ |

IMPLANT TO BE PLACED BY:

- Horizon OMS Referring Doctor

PREFERRED IMPLANT SYSTEM:

- Straumann NeoDent

CLINICAL NOTES / SPECIAL INSTRUCTIONS

IMAGING / X-RAYS

- Please take required X-rays Sent with patient Will be emailed

Requesting phone call to discuss case _____ DATE _____

PATIENT INFORMATION

Please review before your appointment at Horizon OMS of Chicago

WHAT TO BRING TO YOUR APPOINTMENT

- Photo ID (driver's license, state ID, or passport)
- Dental and/or medical insurance card(s)
- This completed referral form
- Any X-rays or imaging provided by your dentist
- List of current medications and known allergies
- Completed patient forms (available at horizon-oms.com or upon arrival)

IF YOUR PROCEDURE IS SCHEDULED WITH IV SEDATION

- Nothing to eat or drink** (including water, gum, and candy) for at least **8 hours** before your appointment
- A responsible adult must drive you** to and from the office and remain in the waiting area during your procedure
- You may **not drive, operate machinery, or make important decisions** for 24 hours after sedation
- Wear a **short-sleeved shirt** and comfortable, loose-fitting clothing
- Remove** nail polish, acrylic nails, contact lenses, and all jewelry before arrival
- No smoking or vaping** for at least 12 hours before and 72 hours after surgery

⚠ IMPORTANT

If you have **not fasted** as instructed, your procedure will need to be rescheduled for your safety. If you are taking blood thinners or have been prescribed antibiotics prior to your visit, please call our office for specific instructions.

INSURANCE & PAYMENT

- Co-pays and estimated patient portions are due at the time of service
- We accept cash, check, all major credit cards, and CareCredit financing
- Complimentary insurance verification — call ahead so we can confirm your benefits

FINDING OUR OFFICE



FREE 2-HR PARKING FOR ALL PATIENTS