WALTER MICHAJLENKO DDS, MD
ORAL & MAXILLOFACIAL SURGERY
Diplomate American Board of Oral & Maxillofacial Surgery

Patient Name _____

SERVICE REQUESTED:

____ Consultation	____ Biopsy	____ Panorex
____ Implant	____ Infection	____ X-rays mailed
____ Extraction	____ Prosthetic Surgery	____ X-rays E-mailed
____ Impaction	____ Chain & Bracket	____ X-rays with patient

____ Other _____

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

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

Comments:

Referring Dr.'s Name _____

Signed _____ Date: _____

APPOINTMENT REQUEST Date: _____ Time: _____

❑ 2780 State Street, #9, Santa Barbara, CA 93105 (805) 687-5541 FAX (805) 687-4406

(PATIENT INSTRUCTIONS ON BACK)