DR. DANIEL C. NIELSON

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GREAT PLAINS
ORAL & MAXILLOFACIAL SURGERY, PA

PATIENT INFORMATION

Patient Name: _____ Phone: _____

DOB: ____ /____ /____ Referring Dr: _____

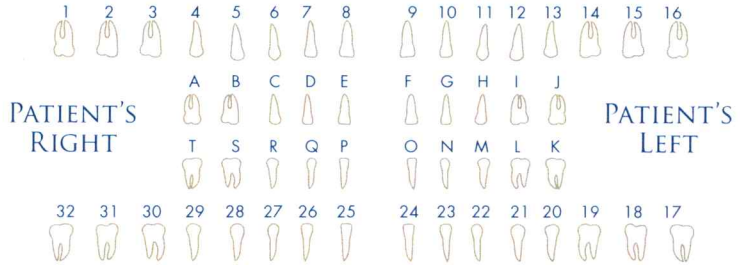
Pre-Med Required: Yes No Taking Blood Thinners: Yes No

Pano or X-ray (circle one): Sent w/ Patient Mailed Emailed *(referral@gpoms.com)*

Treatment Requested: _____

Socket Preservation/Bone Graft requested for planned implant: Yes No

Teeth to be Removed:



Please verify tooth/teeth number(s): _____

Referring Doctor Signature: _____

If you are considering sedation for your treatment, your first visit will involve a consultation with the doctor. You will receive sedation instructions at your consultation.

Please arrive 15 minutes early for your appointment. Make sure to bring a photo ID, insurance cards and any x-rays given to you by your dentist. If you are unable to keep your appointment, please call us at least 24 hours in advance.

Please bring this referral form to your appointment.