



200 E. Willow Suite 103 Wheaton, IL 60187
 630.668.7160 ph 630.668.5815 fx www.docjawi.org

REFERRING:

PATIENT'S NAME

DATE

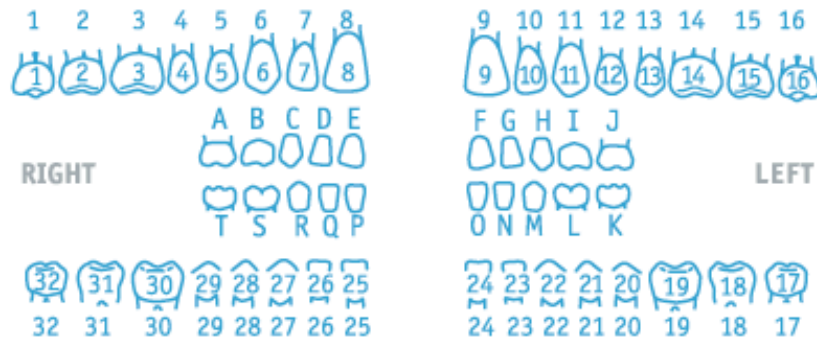
TO: DR. ALAN FORFAR

BY: DR.

EXAM & EVALUATE FOR:

- | | |
|--|---|
| <input type="checkbox"/> Apicoectomy _____ | <input type="checkbox"/> Facial Skeletal Deformity |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> Orthognathic Surgery |
| <input type="checkbox"/> Cyst/Growth Removal | <input type="checkbox"/> Salivary Gland Growth |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Temporomandibular Joint Pain/Dysfunction |
| <input type="checkbox"/> Implants | <input type="checkbox"/> Other _____ |

FOR REMOVAL OF:



INSTRUCTIONS FOR PATIENTS:

1. A preoperative examination is desired. Please contact the office for an appointment prior to surgery and bring this referral slip with you.
2. If you are unable to keep your appointment for any reason, please notify the office promptly.
3. If you are to have a general anesthetic, do not eat or drink for at least six hours before your appointment.
4. You may not drive or go home yourself after receiving a general anesthetic. Please make arrangements to be accompanied to the office and taken home. We prefer your driver remain in the waiting room.
5. Minors must be accompanied by parent or legal guardian.
6. If you have had rheumatic fever, diabetes, heart or vascular surgery, or if you take anticoagulants, please contact us prior to your appointment for special instructions.

**INSTRUCTIONS
FOR
PATIENTS
CONTINUED:**

7. Please use the lavatory before your appointment.
8. Wear loose fitting clothing.
9. The financial obligation for the treatment we provide is your responsibility. We ask that fees be paid at the time services are rendered, unless prior arrangements are made.
10. Payments can be made by cash, check, or bank charge.
11. If you have any questions, please feel free to call the office.

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