



**SFIOS**  
South Florida Institute  
of Oral Surgery

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Oral and Maxillofacial Surgeon  
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South Florida Institute of Oral Surgery  
1800 N Federal Hwy., #201, Pompano Beach, FL 33062

**Appointment Information: This time is reserved specially for you. If you must cancel your appointment, please notify us at least one day in advance.**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Day: \_\_\_\_\_

Introducing: \_\_\_\_\_

Referred for: \_\_\_\_\_

Referred by: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Please Indicate Areas or Teeth to be Evaluated for Treatment**

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



- |  |  |
|--|--|
| <input type="checkbox"/> Wisdom Teeth                        | <input type="checkbox"/> ICat-CT Scan            |
| <input type="checkbox"/> Extraction                          | <input type="checkbox"/> Bone Grafting           |
| <input type="checkbox"/> Ridge Preservation                  | <input type="checkbox"/> Perio - Plastic Surgery |
| <input type="checkbox"/> Orthodontic Exposure                | ___ Root Coverage                                |
| <input type="checkbox"/> Implants                            | ___ Crown Lengthening                            |
| <input type="checkbox"/> Pathology                           | ___ Ridge Augmentation                           |
| <input type="checkbox"/> Surgically Accelerated Orthodontics | ___ Frenectomy                                   |
| <input type="checkbox"/> Orthodontic Anchorage               | <input type="checkbox"/> Other _____             |

- |  |                          |
|--|--------------------------|
| <input type="checkbox"/> Being Mailed / Emailed  | <input type="checkbox"/> |
| <input type="checkbox"/> Given to Patient        | <input type="checkbox"/> |
| <input type="checkbox"/> No Radiographs / Models | <input type="checkbox"/> |
| <input type="checkbox"/> Please Take             | <input type="checkbox"/> |

**Special Instruction or Remarks:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Instructions to Patients:**

You have been referred for specialized care to an Oral & Maxillofacial Surgeon. Our office will make every effort to make your visit with us a comfortable experience. Please assist us by providing the following information at the time of consultation:

- Your referral slip and x-rays, if applicable.
- All patient information and a list of all medications you are currently taking.
- Your medical/dental insurance information and identification cards, if applicable.
- Payment is expected at the time of the initial consultation. We will be happy to assist you with making financial arrangements for your continued care.

**IMPORTANT:** The initial visit, with the exception of certain emergency cases, is for consultation only. This enables us to perform a complete evaluation and deliver the highest quality care specific to your needs.

**Special Instructions for General Anesthetic or I.V. Sedation**

- Do not have anything to eat or drink 6 hours prior to your surgery. **NO FOOD OR DRINK, INCLUDING WATER.** It is extremely dangerous to have anything in your stomach during the anesthetic.
- You must arrange for someone to drive you home after the surgery, and you **CANNOT DRIVE FOR THE REMAINDER OF THE DAY.** Your driver must accompany you and **WAIT** for you in the office during your surgery.
- Eat a light easily digestible meal the night before the surgery. Do not drink alcoholic beverages the night before.
- Wear loose, comfortable clothing with short sleeves