Klene Center
ORAL & FACIAL SURGERY

☐ Patient will call to schedule consultation

☐ Please contact patient to schedule consultation

715 West Carmel Dr. #102, Carmel, IN 46032 | P: 317-208-5525 • F: 317-208-1018
info@klenecenter.com | klenecenter.com

PATIENT INFORMATION

Referral Date: _____ Patient Name: _____

Date of Birth: _____ Parent/Guardian: _____

Patient Phone: _____ Patient email: _____

REFERRING INFORMATION

Referring Doctor: _____ Specialty: _____

Phone: _____ Email: _____

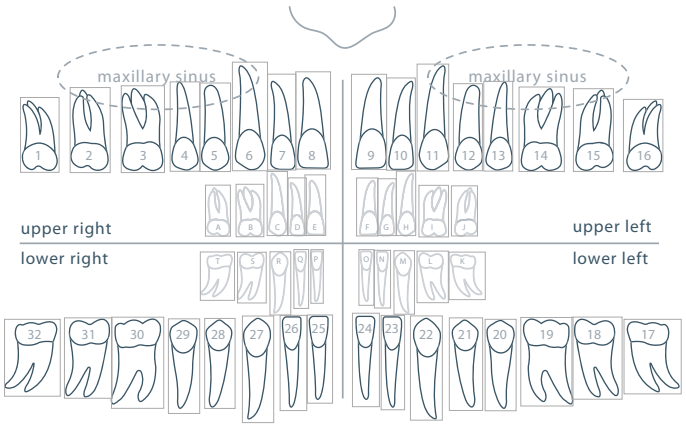
City: _____ State: _____

AREAS FOR EVALUATION

- ☐ Orthognathic Surgery
  - ☐ Proposed Surgical Treatment Plan
    _____
  - ☐ Ortho Treatment Start Date _____
  - ☐ Anticipated Surgery Readiness _____
- ☐ Craniofacial/Cleft Surgery
- ☐ Facial Trauma Surgery
- ☐ Pathology/Biopsy
- ☐ Reconstructive Surgery
- ☐ TMJ Surgery
- ☐ Cosmetic Procedure
- ☐ Infection
- ☐ Dentoalveolar Surgery
  - ☐ Extraction
  - ☐ Alveoloplasty
  - ☐ Exposure
  - ☐ Expose and bond
  - ☐ Frenectomy
  - ☐ Bone grafting
  - ☐ Sinus lift
  - ☐ Vestibuloplasty
- ☐ Implants
  - ☐ Preferred Implant System
    _____
  - ☐ Prosthetic Plan:
    _____
  - ☐ Surgical Guide:
    - ☐ Provided by referral
    - ☐ Surgeon to provide
- ☐ Other: _____

INCLUDED INFORMATION

- ☐ Imaging (Date taken: _____)
  - ☐ Submitted through klenecenter.com
  - ☐ Securely emailed ☐ Mailed to office
  - ☐ Patient to bring ☐ Please take image
  - ☐ No image
- ☐ Clinical Photos (Date taken: _____)
- ☐ Models (Date taken: _____)
- ☐ Patient Treatment Records (Date taken: _____)



PLEASE CIRCLE

ADDITIONAL COMMENTS