



# ORAL FACIAL SURGERY ASSOCIATES

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Introducing  
**MR./MRS./MS.** \_\_\_\_\_

*For an Appointment on*

Date \_\_\_\_\_ Time \_\_\_\_\_

## SURGICAL CONSULTATION REQUESTED

- |  |  |
|--|--|
| <input type="checkbox"/> TMJ           | <input type="checkbox"/> Oral Lesion               |
| <input type="checkbox"/> Implants      | <input type="checkbox"/> Reconstructive Surgery    |
| <input type="checkbox"/> Facial Lesion | <input type="checkbox"/> Tooth extraction as noted |

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	A	B	C	D	E	F	G	H	I	J					
	T	S	R	Q	P	O	N	M	L	K					
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Comments: \_\_\_\_\_

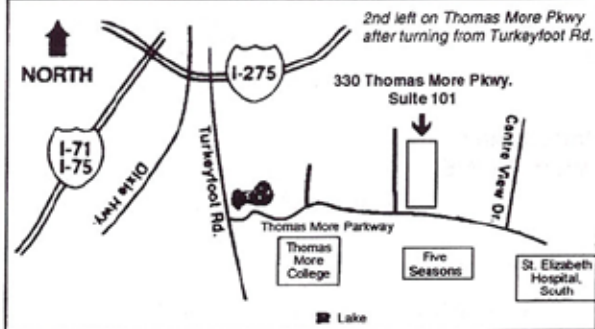
- Please call my office regarding this patient.

Dr. \_\_\_\_\_

Please bring insurance information, list of medications, allergies, and pertinent medical history to your consultation.

# FOR YOUR CONVENIENCE . . .

## Crestview Hills (859) 578-9000



## Union/Florence (859) 371-0123

