



ORAL & IMPLANT SURGERY

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Board Certified Oral & Maxillofacial Surgeons

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Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ DATE: \_\_\_\_\_

Consultation / Procedure:

- |                                                  |                                               |
|--------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> All on X (Dr. Nguyen)   | <input type="checkbox"/> Orthognathic Surgery |
| <input type="checkbox"/> Zygomatic / Pterygoid   | (Dr. Sardzinski)                              |
| <input type="checkbox"/> Implants                | <input type="checkbox"/> Third Molars         |
| <input type="checkbox"/> Bone Graft / Sinus Lift | <input type="checkbox"/> Alveoplasty          |
| <input type="checkbox"/> Exposure / Bracket      | <input type="checkbox"/> Extractions          |
| <input type="checkbox"/> Tori Removal            | <input type="checkbox"/> Incision / Drainage  |
| <input type="checkbox"/> Other _____             | <input type="checkbox"/> Biopsy / Pathology   |

**NOTE:** Indicate teeth to be evaluated/treated with a *circle*. Indicate missing teeth with **X**

|                     |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |
|---------------------|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|
|                     |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |
| 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 |
| _____               |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |
| 3                   | 2 | 3 | 1 | 3 | 0 | 2 | 9 | 2 | 8  | 2  | 7  | 2  | 6  | 2  | 5  |
| 4                   | 3 | 2 | 4 | 2 | 3 | 2 | 2 | 2 | 1  | 2  | 0  | 1  | 9  | 1  | 8  |
| 5                   | 3 | 1 | 3 | 0 | 2 | 9 | 2 | 8 | 2  | 7  | 2  | 6  | 2  | 5  | 4  |
| T S R Q P O N M L K |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |

Radiographs:

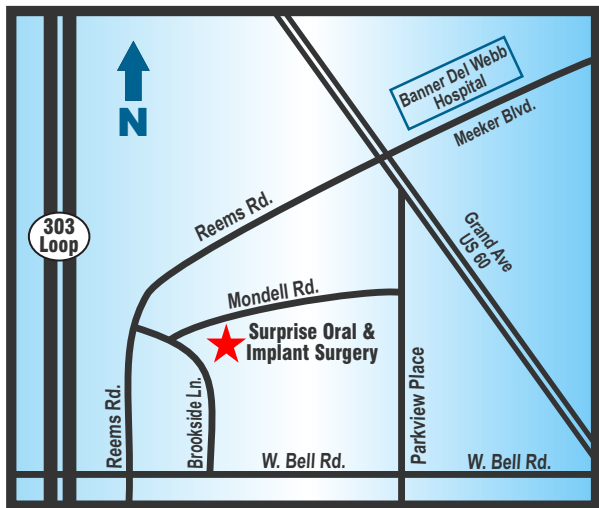
- ☐ Patient to bring to appointment      ☐ Emailing: [office@surpriseazoralsurgery.com](mailto:office@surpriseazoralsurgery.com)      ☐ Please take Radiograph

Remarks: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Office Name: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_

**Please have insurance information available when making appointment**



## CONTRACTED DENTAL INSURANCE

- Aetna PPO
- BC/BS PPO
- Connection Dental
- Delta Dental
- Delta Dental Retiree
- Sun Life PPO
- Humana PPO
- Careington PPO
- United Concordia / Tricare
- MetLife
- Cigna

## DISCOUNT PLANS

- Aetna Discount Plan

## MEDICAL INSURANCE

- Blue Cross Blue Shield PPO

*"We do accept out of network PPO Insurance.  
The patient portion or deductible may be higher.  
Due to the limitations of this plan,  
we are not Medicare providers."*

***So that we can best help you with your plan,  
please have insurance information  
available when making an appointment.***

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