Dr. Brittany Ecker

ECKER
ORAL SURGERY

Dr. Jordan Ecker

Patient Name: _____ *Date:* _____

Referring Doctor: _____

Please Contact Me: ☐ Before ☐ After Seeing Patient

Radiographs: ☐ Provided to Patient ☐ Please Take

☐ Emailed to info@eckeroralsurgery.com

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

Reason for Referral:

☐ Extraction ☐ Bone Graft ☐ Implant ☐ Immediate Temp

☐ Wisdom Teeth ☐ IV Sedation ☐ Biopsy ☐ Apico

☐ All-on-X ☐ CBCT ☐ Exposure ☐ TMJ ☐ Other

Comments: _____

_____

_____

Patient Instructions:

- See reverse side for contact information to schedule your appointment.
- Please make sure to bring this card along with any x-rays and insurance information to your first scheduled appointment.
- If you are considering IV sedation, please let us know when scheduling your appointment, and we will provide you with further information.

ECKER

ORAL SURGERY

Dr. Brittany Martin Ecker

Dr. Jordan Ecker

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