

**OLYMPIA ORAL AND MAXILLO-FACIAL SURGERY**

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Board Certified Diplomate  
American Board of Oral and Maxillofacial Surgery



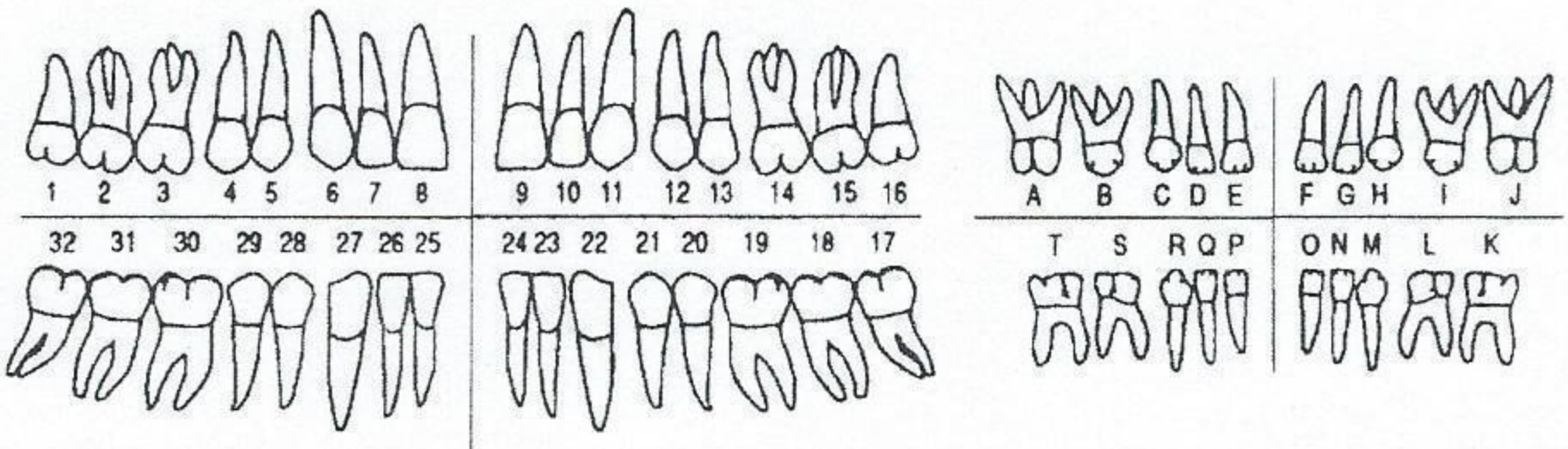
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Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Patient's Telephone # (\_\_\_\_\_) \_\_\_\_\_

Referring Doctor \_\_\_\_\_

**PLEASE EXTRACT TEETH AS MARKED (X)**



**OTHER SURGERY INSTRUCTIONS:**

- BIOPSY AREA \_\_\_\_\_
- IMPLANTS
- ORTHOGNATHIC SURGERY     OTHER

REMARKS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE SEND MORE REFERRAL FORMS