Date: _____/_____/_____

WEST BALLANTYNE ORAL SURGERY

**Dr. George Y. Soung, DDS, FAAOMS, FACOMS**
**Board Certified Oral & Maxillofacial Surgeon**

Patient Name: _____ DOB: _____/_____/_____

Patient's Phone Number: (_____) _____ - _____

Practice Name: _____

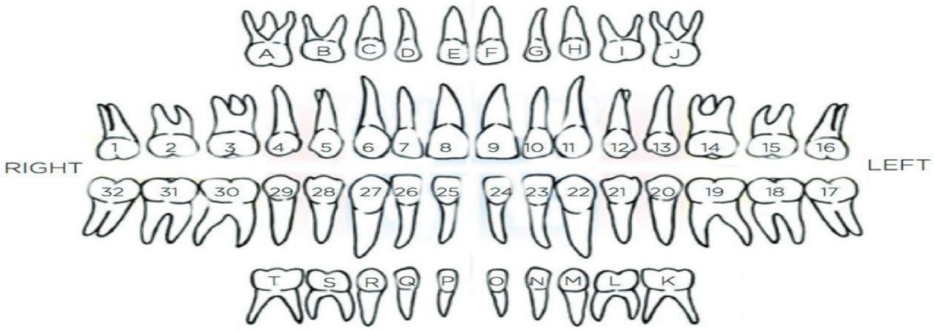
Referring Doctor: _____

Office Number: (_____) _____ - _____

**Procedure:**

☐ Extractions ☐ Bone Grafting ☐ Biopsy ☐ Alveoloplasty ☐ Sinus Lift

☐ Expose & Bond ☐Torus Removal ☐ Implants ☐Ridge Augmentation ☐Other




Comments:

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**14746 Lancaster Hwy Ste. B**
**Pineville, NC 28134**
**Phone:** 704-583-5217 **Fax:** 704-200-9913
**Email:** office@westballantyneoralsurgery.com