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PATIENT INFORMATION

Referral Date: ______________________

Patient Name: ____ Date of Birth: ___________________________

Phone: ______________________________ E-mail: ____

REFERRING DOCTOR'S INFORMATION

Referring Doctor: ____

Phone: ____________________________ E-mail: ____

CONSULTATIONS & PROCEDURES

☐ Implants
☐ Bone Grafting
☐ Sinus Lift
☐ Wisdom Teeth
☐ Expose & Bond
☐ Extractions
☐ All-On-4
☐ Lesion Evaluation
☐ Incision & Drainage
☐ Alveoplasty
☐ Tori Removal
☐ Soft Tissue
☐ Biopsy
☐ Orthognathic Evaluation
☐ Frenectomy
☐ Pre-Prosthetic
☐ Other

Please Circle Teeth to be Treated

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Decidious

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

Please Verify Teeth for Extraction: ____

RADIOGRAPHS OR CLINICAL PHOTOS

☐ Being Emailed
☐ Given to Patient
☐ Please Take
☐ No X-Ray

If X-Rays are attached, what date were they taken:

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COMMENTS

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