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Oral and Maxillofacial Surgery



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Referring Dr: \_\_\_\_\_ Date: \_\_\_\_\_

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

Would you like us to contact the patient to schedule: Y / N

If yes, patient phone number: \_\_\_\_\_

Please Circle Extraction:

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

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

Please Examine for:

Extractions

Bone Graft

Pathology

Implants

General Anesthesia

Other

Radiographs:

Please Take

Enclosed

Emailed

Given to Patient

Remarks and Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Consultation Appointment: \_\_\_\_\_

Day

Date

Time