e l e v ʌ t e d

ORAL & MAXILLOFACIAL SURGERY

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Introducing Patient: ______________________________

Contact PH# (C) ______________ **(H)** ______________ **(W)** ______________

Consultation / Procedure:

- ☐ Third Molars
- ☐ Implants
- ☐ Grafting/Augmentation
- ☐ Exodontia
- ☐ Pre-prosthetic
- ☐ TMJ
- ☐ Ortho - Expose/Bond
- ☐ Biopsy
- ☐ Other: ______________________________

Note: Indicate teeth/area to be evaluated/treated with an X.

A B C D E F G H I J

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

R ______________________________ L

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

T S R Q P O N M L K

Radiographs:

- ☐ Patient to bring
- ☐ Being sent
- ☐ Please obtain
- ☐ Cone Beam CT
- ☐ Please return
- ☐ Keep
- ☐ Email to: rjrusselloms@gmail.com

Remarks: ______________________________

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Referring Doctor: ______________ **Date:** __________ **PH:** __________