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Patient Name: _____ DOB:_____

Consultation:

☐ Third Molars ☐ Bone Graft ☐ Exposure / Bracket ☐ TMJ
☐ Extractions ☐ Alveoplasty ☐ Sleep Apnea / Snoring ☐ Implants
☐ Apicoectomy ☐ Orthognathic Surg ☐ Soft Tissue / Pathology
☐ Other: _____

NOTE: Indicate teeth to be evaluated/treated with a *circle*. Indicate missing teeth with **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

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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

Procedure:

☐ Third Molars ☐ Biopsy ☐ Extractions
☐ Implants ☐ Incision / Drainage ☐ Alveoplasty
☐ Other: _____

Radiographs:

☐ Patient to bring ☐ Being sent ☐ Please obtain
☐ Please return ☐ Keep ☐ Email
to:_____

Remarks: _____
_____
_____

Significant Past Medical History: _____
_____
_____

Dentist's Signature: _____ **Date:** _____