Metropolitan Oral & Maxillofacial Surgery Associates

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Introducing _____ Phone _____

Patient's Address _____

Referred by Dr. _____ Dr. requests call prior to seeing patient? _____

Radiographs: ❑ Enclosed ❑ Will Bring ❑ No X-ray Available ❑ Please Take

Please evaluate and provide treatment for the following:

❑ Extractions	❑ Apicoectomy	❑ Biopsy	❑ Other
❑ Dental Implants	❑ Trauma	❑ Tori Removal	_____
❑ Crown Lengthening	❑ TMJ Disorder	❑ Frenectomy	_____
❑ Facial Cosmetic Surgery	❑ Orthognathic Surgery	❑ Exposure	_____

(please specify)_____

_____

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

Right

A	B	C	D	E
T	S	R	Q	P

Left

F	G	H	I	J
O	N	M	L	K

Remarks: _____

Future Restorative Plan: _____

A. Patient copy B. Copy to be mailed to Specialist