



SD Oral, Facial & Implant Surgery

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Date: _____

Patient Name: _____ Daytime Phone: _____

Referring Doctor: _____ Office Phone: _____

Radiographs: ☐ Please Take ☐ Emailed ☐ Mailed ☐ With Patient

Please evaluate and treat:

- ☐ Extractions
- ☐ Bone Grafting
- ☐ Implants
- ☐ Oral Pathology
- ☐ A04 / All-on-X
- ☐ Expose & Bond
- ☐ Other _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
A B C D E								F G H I J							
T S R Q P								O N M L K							
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Medical Alerts: _____

Remarks: _____
