

Date: Referring Dr. Phone:

Patient's Name: DOD: Phone:

Referral for:

- Extraction Teeth# _____ (Please Mark Teeth On Diagram)
- Alveoloplasty: UR _____ UL _____ LR _____ LL _____
- Mandible Lingual Torus: Right _____ Left _____
- Palatal Torus
- Buccal Exostosis
- Surgical Exposure Teeth # _____
- Gold Chain Bond: Yes _____ No _____
- Frenectomy: Lingual _____ Buccal _____
- Apicoectomy Teeth# _____ (Please Mark Teeth On Diagram)
- Soft Tissue: UR _____ UL _____ LR _____ LL _____
- Bone Graft: UR _____ UL _____ LR _____ LL _____
- Sinus Lift: Right _____ Left _____ Bilateral _____
- Corticotomy: UR _____ UL _____ LR _____ LL _____
- Infection _____
- Incision and Drainage _____
- Oral And Facial Pathology (Lesion) _____
- Orthognathic Surgery (OGS) Evaluation _____
- Cleft Lip and Palate _____
- TMJ _____
- Cosmetic Facial Surgery _____
- Intraoral Trauma: Soft Tissue _____ Dentoalveolar _____
- Facial Trauma _____
- Dental Implant: Teeth# _____
Preference _____

X Rays:

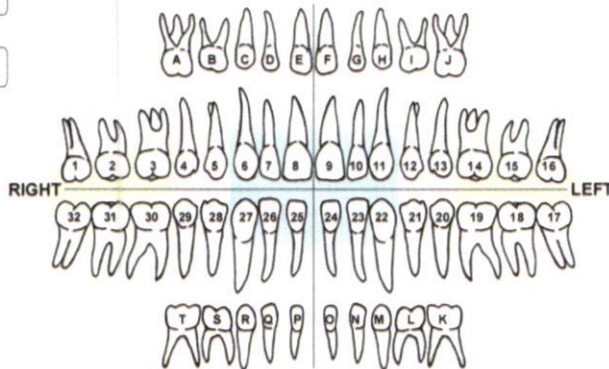
- Panoramic _____
- Occlusal _____
- PA _____
- BW _____
- CBCT _____

- Mailed _____
- Give to Patient _____
- N/A _____

Anesthesia:

- Local _____
- Nitrous Oxide _____
- IV Sed _____
- General Anes (OR) _____

Primary And Permanent Teeth Chart



Supernumerary Teeth Chart

51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66
R															L
82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

Comments: _____

