Desert Oral Surgery

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PATIENT INFORMATION

Today's Date: _____

First Name: _____ Last Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Contact Telephone: _____ Contact Email: _____

Patient Insurance Provider: _____

REFERRING DOCTOR'S INFORMATION

Referred by: _____ Telephone: _____

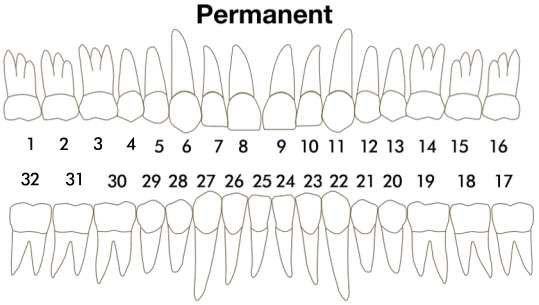
Email Address: _____

PROCEDURES/CONSULTATIONS

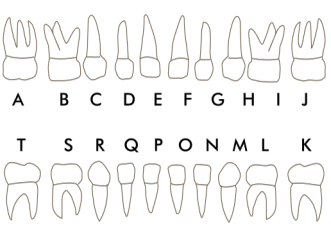
- ☐ Extraction(s)
- ☐ Implants
- ☐ Tori-Palatal
- ☐ Tori-Mandibular
- ☐ Excision Benign Tumor
- ☐ Frenectomy
- ☐ Vestibuloplasty
- ☐ General Anesthesia
- ☐ Expose/Bond Tooth # _____
- ☐ Apicoectomy Tooth # _____
- ☐ Biopsy
- ☐ Alveoloplasty
- ☐ Orthognathic Evaluation
- ☐ Tuberosity Reduction
- ☐ Incision & Drainage of Abscess
- ☐ Consultation Only

Please Verify Teeth for Extraction/Implant: _____

Permanent



Deciduous



CASE NOTES

_____

_____

_____

_____

_____

_____

_____

RADIOGRAPHS OR CLINCAL PHOTOS

Periapical available Dated: _____

Panorex available Dated: _____