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Patient Name: _____ DOB: _____

Consultation:

- | | | | |
|---------------------------------------|--|--|-----------------------------------|
| <input type="checkbox"/> Third Molars | <input type="checkbox"/> Bone Graft | <input type="checkbox"/> Exposure / Bracket | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Extractions | <input type="checkbox"/> Alveoplasty | <input type="checkbox"/> Sleep Apnea / Snoring | <input type="checkbox"/> Implants |
| <input type="checkbox"/> Apicoectomy | <input type="checkbox"/> Orthognathic Surg | <input type="checkbox"/> Soft Tissue / Pathology | |
| <input type="checkbox"/> 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

	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:

- | | | |
|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Third Molars | <input type="checkbox"/> Biopsy | <input type="checkbox"/> Extractions |
| <input type="checkbox"/> Implants | <input type="checkbox"/> Incision / Drainage | <input type="checkbox"/> Alveoplasty |
| <input type="checkbox"/> Other: _____ | | |

Radiographs:

- | | | |
|---|-------------------------------------|--|
| <input type="checkbox"/> Patient to bring | <input type="checkbox"/> Being sent | <input type="checkbox"/> Please obtain |
| <input type="checkbox"/> Please return | <input type="checkbox"/> Keep | <input type="checkbox"/> Email |

to: _____

Remarks: _____

Significant Past Medical History: _____

Dentist's Signature: _____ Date: _____