



Patient Name: _____

DOB: _____ Date: _____

Patient Email: _____

Patient Phone: _____

Referred by Dr. _____

Phone Number: _____

Practice Name: _____

Oral Surgery

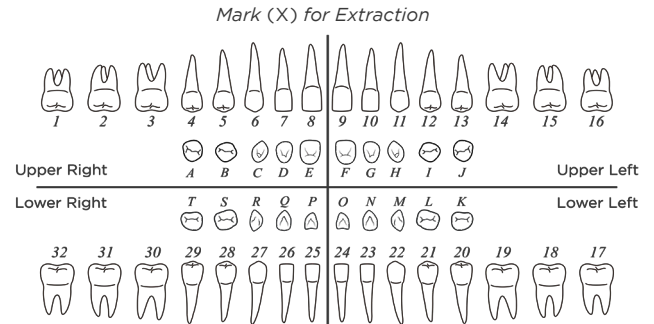
Wisdom Teeth Evaluation #s: _____

Tooth Extraction(s) #s: _____

Pathology Evaluation/Biopsy _____

Other _____

Additional Comments: _____



Dental Implants

Patient Assessment: _____

Other Concern(s): _____

Tissue Former Immediate Provisional #s: _____

Digital Scan Requested Preferred Lab: _____

TMD & Orofacial Pain Treatment Planning

Please evaluate for possible:

- Myofascial Pain
 Joint Noises
 Abnormal X-ray Findings
 Neuralgia
 Neuropathy
 Joint Pain/Pain on Function
 Closed Lock/Limited Mouth Opening
 Open Lock
 Headaches/Ear Pain

Additional Comments: _____

Urgent

Orthognathic & Treatment Planning

Maxillary Surgery
 Mandibular Surgery
 Chin Surgery

Additional Comments: _____

X-ray(s) taken on date _____

- Submitted through mycenters.com
 Mailed to Office
 Please Take X-ray
 Emailed to Specific Office Location
 Given to Patient
 None Available



Additional Comments: _____

Please select a location and doctor:

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