

	DRAL & MAXILLOFA	CIAL SURGERI
PATIENT INFORMATION:		
Today's Date		
First Name	Last Name	Date of Birth
Parent / Guardian Name		
Contact Telephone	Contact E-Mail Address	
Does the patient require antibiotics prior to denta	al treatment? 🗆 Yes 🗅 No	
REFERRING DOCTOR'S INFORMATION	ON:	
Referred By		Telephone
E-Mail Address		
REASON FOR REFERRAL:		
REAGON FOR REFERENCE.		
-		_
CROSS OUT ANY TEETH TO BE EXTRACTED W	TITLI ANI V.	
Choos out and Teeth To be extracted w	IIII AN A.	
ADULT TEETH		PRIMARY TEETH
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£0000000000000000000000000000000000000	PATIENT 24 25 26 27 28 76	PATIE 55 54 53 52 51 61 62 63 64 65 To
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18 17 16 15 14 13 12 11 21 22 23 18 48 47 46 45 44 43 42 41 31 32 33		PATIENT'S LEFT SIDES NO. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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0 0	• • •	
Please Verify Teeth		
RADIOGRAPHS OR CLINICAL PHOTO	ne.	
☐ Being Mailed	<u> </u>	
☐ Given To Patient		
☐ Please Take ☐ No X–Ray		
If X-Rays are attached, what date were they take	en	
INSURANCE INFORMATION OR ADDITIO	NAL COMMENTS:	
INSURANCE INFORMATION OR ADDITIO	NAL COMMENTS:	
-		
Signature of Referring Dentist/Physician:		

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