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Patient \_\_\_\_\_ Date \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

Significant Medical History \_\_\_\_\_

**I. Teeth To Be Removed**

1. Please select on chart:

2. Which of these are:

Fully Erupted \_\_\_\_\_

Impacted \_\_\_\_\_

Root or Root Tips \_\_\_\_\_

Diagnosis \_\_\_\_\_

	1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16		
		A	B	C	D	E				F	G	H	I	J					
R		T	S	R	Q	P				O	N	M	L	K					L
	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17		

3. Is a recent panoramic or PA available?    Yes    No    Date \_\_\_\_\_

**II. Exam and Consultation**

Implants \_\_\_\_\_ Orthognathic \_\_\_\_\_

Extractions \_\_\_\_\_ Lesions \_\_\_\_\_ TMJ \_\_\_\_\_

**III. Other Procedures**

Biopsy \_\_\_\_\_ Frenectomy \_\_\_\_\_

Alveoplasty \_\_\_\_\_ Apicoectomy (Tooth #) \_\_\_\_\_

**IV. Comments**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Referring Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Referred To \_\_\_\_\_