ROUND ROCK
ORAL SURGERY
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Date:_____

Patient Name:_____ **DOB:**_____

Referring Dr.: _____

Referring Dr. Phone:_____ **Email:**_____

- ❑ Consultation & Evaluation
- ❑ Preprosthetic Surgery
- ❑ Dental Implants
- ❑ Bone Graft/Preservation
- ❑ Expose and Bond
- ❑ Upright Molar
- ❑ Frenectomy
- ❑ Apicoectomy:_____
- ❑ Infection
- ❑ Pathology/Biopsy
- ❑ Salivary Gland Evaluation
- ❑ Trauma
- ❑ Extractions:_____
- ❑ Other: _____

Radiographs:

- ❑ PA ❑ Please Take ❑ Emailed ❑ Given to Patient
- ❑ Pano
- ❑ Cone Beam CT

UPPER

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

LOWER

UPPER

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

LOWER

Comments: