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Patient Name _____
Telephone _____ Cell _____
D.O.B. ____/____/____

Referring Doctor _____
Telephone _____ Fax _____
Appt Date ____/____/____ Time ____

Indicate Area (s):

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

- ORAL SEDATION OR GENERAL ANAESTHESIA
- Evaluation and treatment Plan for implant supported prostheses / Sinus lift
- Extraction of tooth # _____ with immediate / implant placement /
Temporization / grafting
- Fixed Restoration of _____ Maxilla / Mandible Edentulous arch
- Implant Supported Restoration _____
- Tension Headache & Trigger Point Injections _____
- Notes: _____

