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In our effort to provide better patient service, please fax/email this form to our office.  
 Also provide the patient with a copy to bring to their appointment. Thank You!

**PATIENT INFORMATION:**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_  
 Contact Phone: \_\_\_\_\_ Contact Email: \_\_\_\_\_

**REFERRING DOCTOR:**

Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_

**PLEASE INDICATE AREA TO BE TREATED**

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

- Extraction: \_\_\_\_\_
- Implant / Bone Graft: \_\_\_\_\_
- Alveoplasty: \_\_\_\_\_
- Other: \_\_\_\_\_

**RADIOGRAPHS/CLINICAL PHOTOS:**

- Email  Sent with Patient  Please Take  Attached (Date: \_\_\_\_\_ )

**Please see the reverse side  
 for a map to our office.**

Please bring any x-rays or insurance information to your appointment.