San Gabriel Oral & Maxillofacial Surgery Associates, P.A.

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***Board Certified:**
American Board of Oral and Maxillofacial Surgery

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Date: ______________________________

Patient Name: ______________________________

Referring Doctor: ______________________________

Telephone: ______________________________

X-RAYS:

❑ Sent with Patient

❑ Mailed ❑ Please Take

MEDICAL/DENTAL RECORDS:

❑ Sent with Patient

❑ Mailed

PROCEDURES:

❑ Removed Teeth Marked (X)

PERMANENT

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

RIGHT **DECIDUOUS** **LEFT**

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

❑ Trauma

❑ Supernumery teeth (please indicate location)

SERVICES

❑ CONSULTATION
- ❑ orthognathic surgery
- ❑ pathology
- ❑ reconstructive jaw surgery

❑ OSSEOINTEGRATED IMPLANTS

❑ TISSUE REMOVAL

❑ EXPOSURE

❑ REMARKS ______________________________

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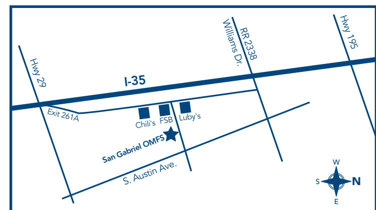
YOUR APPOINTMENT HAS BEEN SCHEDULED FOR:

Date: ______________________________

Time: ______________________________

We Appreciate Your Promptness Concerning Your Appointment



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