DOWNEY
ORAL & MAXILLOFACIAL SURGERY

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Date: _____

Introducing: _____

Daytime Telephone: _____

Appointment Information:

Date: _____ Time: _____

Referred By: _____

Please circle the teeth or area(s) to be evaluated:

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

☐ Wisdom Teeth Removal	☐ Dental Implant Tooth Replacement
☐ Extraction(s)	☐ Bone Graft / Sinus Lift / Socket Preservation
☐ Pre-Prosthetic Surgery	☐ Infection / Incision & Drainage
☐ Expose & Bond	☐ Biopsy / Oral Medicine
☐ Trauma	☐ Orthognathic Surgery
Other:	

☐ X-Rays needed ☐ X-Rays given to patient ☐ X-Rays E-mailed or sent

Additional Comments:

_____
_____
_____
_____

_____
Doctor's Signature