Clark & Patel
Oral & Maxillofacial Surgery

*Office Use Only*

Patient Name_____

Date of Referral_____

Please indicate by an "X" the teeth to be removed.

| | |
|---|---|
| A B C D E | F G H I J |
| 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 |

Remarks: _____

_____

_____

Referring Doctor_____

Appointment Date_____

Appointment Time_____

[ ] Patient will bring radiographs

[ ] Radiographs have been mailed

[ ] Please take necessary radiographs

[ ] Please take Cone Beam CT Scan

Please evaluate the patient for:

[ ] Implants

[ ] Pathology

[ ] TMJ

[ ]Sleep Apnea

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