



PATIENT NAME

REFERRED BY DR.

RADIOGRAPH SENT?

No     In Mail     With Patient

APPOINTMENT DATE

APPOINTMENT TIME

PATIENT ON RX

REASON FOR CONSULTATION

Extraction     Biopsy     Infection     Alveoplasty     Exposure  
 Hard/Soft Tissue     Apicoectomy     Frenectomy     Ligation

PLEASE CIRCLE TEETH TO BE TREATED

Please circle teeth to be treated

	1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16	
Left																		Right
	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17	

Deciduous

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

OTHER INFORMATION