EASTERN SHORE
ORAL, FACIAL AND IMPLANT SURGERY CENTER

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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: Today's Date: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Parent/Guardian Name: _____

Contact Phone: _____ Contact Email: _____

REFERRING DOCTOR: Referred By: _____

Phone: _____ Email: _____

Address: _____

Diagnosis: _____

PREFERREDE METHOD OF CONTACT: ☐ Email ☐ Postal Mail ☐ Phone

PLEASE INDICATE AREA TO BE TREATED

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
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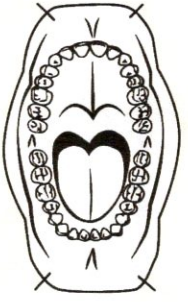
R				E	D	C	B	A	A	B	C	D	E				L
				E	D	C	B	A	A	B	C	D	E				
	32	31	30	29	28	27	26	25	LOWER	24	23	22	21	20	19	18	17



☐ Extraction: _____ ☐ Bone Graft: _____

☐ Implant: _____ Preferred Implant System: _____

☐ Pre-Prosthetic Surgery: _____ ☐ TMJ: _____

☐ Exposure/Expose & Bond: _____ ☐ Biopsy: _____

☐ Orthognathic Surgery: _____

☐ Other: _____

_____

_____

RADIOGRAPHS/CLINICAL PHOTOS:

☐ Email ☐ Mailed ☐ Sent with Patient ☐ Please Take ☐ No Xray ☐ Attached (Date: _____)

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

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