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Oral,  
Facial &  
Implant  
Surgery

# D

## SD Oral, Facial & Implant Surgery

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Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

DOB: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Radiographs:  Please Take  Emailed  Mailed  With Patient

Please evaluate and treat:

- Extractions  Bone Grafting
- Implants  Oral Pathology
- A04 / All-on-X  Expose & Bond
- Other \_\_\_\_\_

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
A B C D E								F G H I J							
T S R Q P								O N M L K							
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Medical Alerts: \_\_\_\_\_

Remarks: \_\_\_\_\_

\_\_\_\_\_

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