ORAL & MAXILLOFACIAL SURGERY

American Board Certified Oral & Maxillofacial Surgeons

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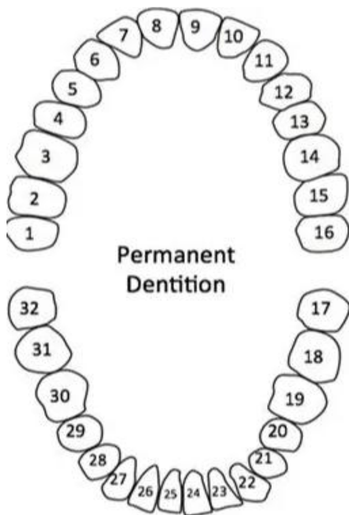
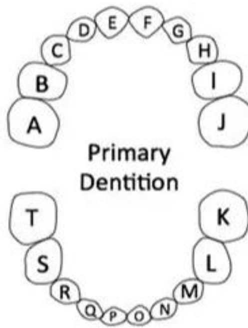
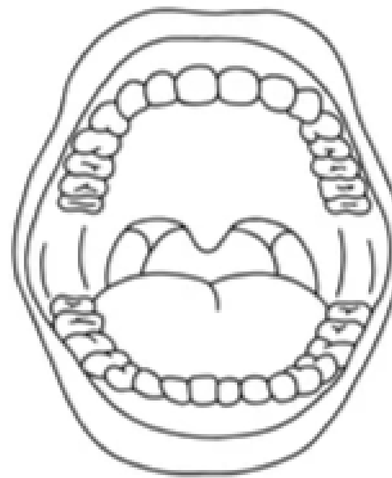
Patient's Name____ DOB____________________

Appointment Date____Time____________________

Referring Doctor____ Phone____________________







REQUESTED TREATMENT:

☐Extraction(s) (Mark on diagram above)
☐Socket Preservation
☐Implant: Location_________
☐Surgical Exposure-With or Without Bracket
☐Orthognathic
☐Trauma

☐ Pathology (Mark on diagram above)
☐Tori Removal
☐Alveoloplasty: Location____________
☐Frenectomy
☐CBCT
☐Other___________________________

Radiographs: ☐ Emailed: Referral@hwhpc.com ☐ Mailed
☐ Given to Patient ☐Please Take

Notes:____
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