MIDTOWN ORAL & MAXILLOFACIAL SURGERY

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Board Certified, American Board of Oral & Maxillofacial Surgery
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Board Eligible, American Board of Oral & Maxillofacial Surgery

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Date / / D.O.B / /

Patient Name _____ Ph# _____

Referring Doctor _____ Ph# _____

☐ Orthognathic Surgery
  ☐ Maxillary surgery ☐ Mandibular surgery ☐ Chin

☐ Implant evaluation of the following areas _____

_____

☐ Pathology - location _____

☐ Frenectomy
  ☐ Maxillary Labial ☐ Lingual

☐ Temporomandibular Joint Disorder
  ☐ popping/clicking ☐ locking ☐ restricted opening ☐ other_____

☐ Other _____

☐ Extraction of indicated teeth (marked with an "x" on the diagram below)

☐ Surgical exposure/uprighting of the following impacted teeth (circle teeth):
  ☐ Expose only
  ☐ Expose and place orthodontic bracket
  ☐ Expose and place bracket with gold chain

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

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

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Plese send referral and any pertinent documentation to patientinfo@midtownomsatx.com