Gainesville
Oral and Maxillofacial Surgery

**oralsurgeryofgainesville.com**

TODAY'S DATE _____ FROM DR. _____

PATIENT _____
First Name Last Name

AGE _____ TELEPHONE _____

**PLEASE MARK AREA FOR TREATMENT**

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

____ Wisdom Teeth Removal
____ Extraction
____ Bone/Soft Tissue Grafting
____ Orthognathic Surgery Evaluation
____ Other: _____

____ Expose & Bond
____ Dental Implants
____ Pre-Prosthetic Surgery
____ Pathology/Biopsy
____ IV Sedation/Anesthesia

REMARKS: