TRIANGLE IMPLANT CENTER
DENTAL IMPLANTS & ORAL SURGERY

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From Dr. _____ Date _____

Introducing _____ Phone _____

Patient is being referred for evaluation of:

I. Extraction or Surgical Removal of teeth indicated by the following Number(s) and / or Letter(s)

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

A B C D E / F G H I J

T S R Q P / O N M L K

AVAILABLE RADIOGRAPHS _____ PANO _____ PAX

II. Other Oral Surgery

Biopsy _____ Exposure (Tooth #) _____

Apicoectomy (Tooth#) _____ Preprosthetic Surgery _____

Frenectomy _____ Other _____

III. Consultation

Implants _____ TMJ Problem _____

Trauma _____ Orthognathic Surgery _____

Ridge Augmentation _____ Other _____

IV. Periodontal Procedures: _____ Gingival Grafts

_____ Crown Lengthening

V. Special Instructions _____

Patients are ALWAYS seen for an initial consultation before any surgical procedures are scheduled.