TRIANGLE IMPLANT CENTER
DENTAL IMPLANTS & ORAL AND MAXILLOFACIAL SURGERY

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triangleimplantcenter.com

From Dr. _____ Date _____

Introducing _____ Phone _____

Appointment Time _____

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 and Maxillofacial Surgical Procedures

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.

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