Maxillofacial Surgery of Greenwich, LLC
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Patient Name: _____ DOB:_____

Consultation:

☐ **Third Molars** ☐ **Bone Graft** ☐ **Exposure / Bracket** ☐ **TMJ**
☐ **Extractions** ☐ **Alveoplasty** ☐ **Sleep Apnea / Snoring** ☐ **Implants**
☐ **Apicoectomy** ☐ **Orthognathic Surg** ☐ **Soft Tissue / Pathology**
☐ **Other:** _____

NOTE: Indicate teeth to be evaluated/treated with a *circle*. Indicate missing teeth with **X**

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

Procedure:

☐ **Third Molars** ☐ **Biopsy** ☐ **Extractions**
☐ **Implants** ☐ **Incision / Drainage** ☐ **Alveoplasty**
☐ **Other:** _____

Radiographs:

☐ **Patient to bring** ☐ **Being sent** ☐ **Please obtain**
☐ **Please return** ☐ **Keep** ☐ **Email to:**_____

Remarks: _____
_____
_____

Significant Past Medical History: _____
_____
_____

Dentist's Signature: _____ **Date:** _____