NASHVILLE ORAL SURGERY
ORAL | MAXILLOFACIAL | IMPLANT SURGERY
NashvilleOralSurgery.com
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ORAL SURGERY EVALUATION/ TREATMENT REQUEST

Patient Name: _____ **Date:** _____

Patient Phone: (_____) _____ **Referred by:** _____

Referrer Email: _____

Please circle the teeth or areas to be evaluated:

RIGHT LEFT

			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			

Reason For Visit: _____

_____

_____

X-Rays: ○ Needed ○ Emailed ○ Given to Patient ○ Mailed

IMPORTANT PATIENT INFORMATION

Appointment Date: _____ **Appointment Time:** _____

- *A parent or legal guardian must accompany patients under 18 at the time of the initial consultation.*
- *Please bring all x-rays, this referral slip, a list of all your medications with dosages, and your medical and dental insurance cards.*
- *Patients desiring sedation must speak directly to our office staff for detailed instructions before their appointment.*