ARROWHEAD

ORAL & MAXILLOFACIAL SURGERY

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Date _____Referring Dr. _____

Patient Name _____

Please Evaluate (check one):

- ☐ Wisdom Teeth
- ☐ Dental Implant(s)
- ☐ Pre-prosthetic Surgery
- ☐ Extractions
- ☐ Orthognathic Surgery
- ☐ Surgical Crown Lengthening
- ☐ Facial Reconstructive Surgery

Please Extract:

Upper Right

			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			

Other Procedures & Remarks