DCB ASSOCIATES
Oral Maxillofacial Surgery

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NOTE:
Patients requiring the use of general anethesia should not have food or liquid for six (6) hours prior to this appointment.
Please have someone with you to drive home.

INTRODUCING

Patient's Name : _____ Date: _____

Referring Doctor: _____

Appointment: Day _____ Date _____ Time_____

(X) FOR EXTRACTION (O) FOR EVALUATION

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
			A	B	C	D	E	F	G	H	I	J			
			E	D	C	B	A	A	B	C	D	E			
			E	D	C	B	A	A	B	C	D	E			
			T	S	R	Q	P	O	N	M	L	K			
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

REMARKS

- ☐ Wisdom Teeth
- ☐ Dental Implants
- ☐ Dental Extractions
- ☐ Orthognathic Surgery
- ☐ Orthodontic Diagnosis
- ☐ Orthodontic Treatment Plan
- ☐ Sleep Apnea
- ☐ Facial Pain
- ☐ Temporamandibular Joint Dysfunction
- ☐ Pathology
- ☐ Trauma
- ☐ Radiographic Services
- ☐ Panoramic Xray
- ☐ Cone Beam CT Scan
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____