



ORAL & MAXILLOFACIAL SURGERY

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Bluffton, SC 29910

Date: _____ Referred By: _____

Patient Name: _____ Office Telephone: _____

Patient Telephone: _____ Office Fax/E-mail: _____

Please Circle Teeth to be Extracted

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			

Please Verify Tooth Numbers: _____

Additional Consultation and Treatment:

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="radio"/> Dental Implants <input type="radio"/> Surgical Template <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pre-prosthetic Surgery <input type="radio"/> Expose and Bond <input type="radio"/> Frenectomy <input type="radio"/> Bone Graft/Soft Tissue Graft / Sinus Lift <input type="radio"/> Infection <input type="radio"/> Other: _____ | <ul style="list-style-type: none"> <input type="radio"/> Cosmetic Surgery/Botox/Injectable Fillers <input type="radio"/> Pathology <input type="radio"/> Orthognathic Surgery <input type="radio"/> Facial Trauma & Reconstruction <input type="radio"/> TMJ <input type="radio"/> Sleep Apnea <input type="radio"/> Cleft Lip & Palate |
|--|--|

Comments: