



GREATER BOSTON
ORAL SURGERY
& IMPLANT CENTER

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Please fill out this form completely and email or fax it back to our office.

Patient Name: _____ Date: _____

Patient Phone Number: _____

Referring Doctor: _____ Hygienist: _____

Appointment Status: Date: _____ Time: _____ Or patient will call to schedule

			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			

Oral Surgery Procedures to be Performed:

- | | |
|---|---|
| <input type="checkbox"/> Wisdom Teeth | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Extraction: Teeth # _____ | <input type="checkbox"/> TMD |
| <input type="checkbox"/> Implant | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Immediate Implant | <input type="checkbox"/> Corrective Jaw Surgery |
| <input type="checkbox"/> Full Arch Implant Consultation | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Bone/Tissue Grafting | <input type="checkbox"/> Frenectomy |
| <input type="checkbox"/> Exposure and Bonding | <input type="checkbox"/> Alveoplasty |
| <input type="checkbox"/> Infection | |

Radiographs:

- Type: Pano _____ PA _____
- Date taken: ___/___/___
- Sent in the mail
- With Patient
- EMAILED TO:
referral@greaterbostonoralsurgeon.com
- Please take

Please send recent radiographs. An FMX would be appreciated if you have one.

Comments:
