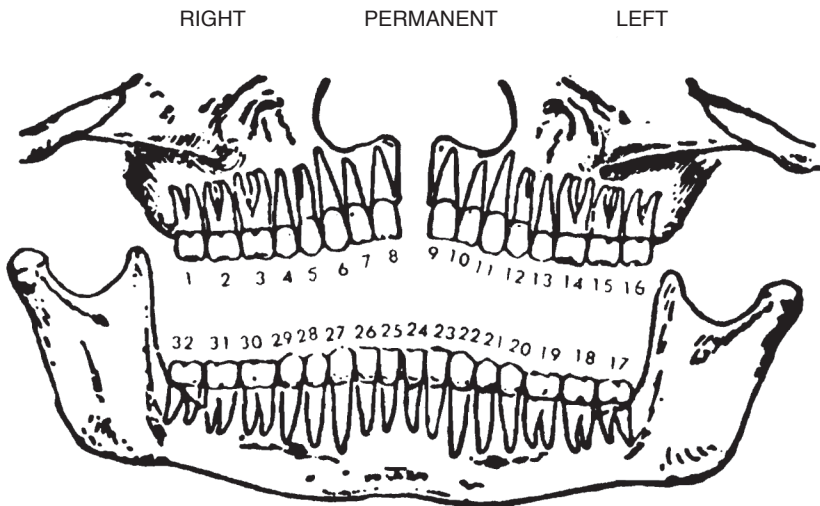
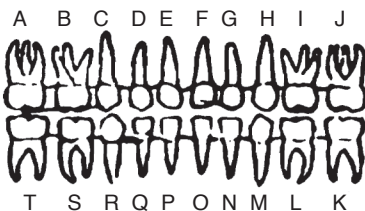


Patient's Name _____



RIGHT DECIDUOUS LEFT



- | | | |
|---|--|---|
| <input type="checkbox"/> ALVEOLECTOMY
<input type="checkbox"/> BIOPSY
<input type="checkbox"/> CONSULTATION
<input type="checkbox"/> ORTHOGNATHIC SURGERY
<input type="checkbox"/> APICOECTOMY
<input type="checkbox"/> ORO-ANTRAL FISTULA CLOSURE | <input type="checkbox"/> CYSTECTOMY
<input type="checkbox"/> MAX & MAND AUGMENTATION
<input type="checkbox"/> FRENECTOMY
<input type="checkbox"/> EXCISION OF HYPERPLASTIC TISSUE
<input type="checkbox"/> DENTAL EXTRACTION
<input type="checkbox"/> DENTAL IMPLANTS | <input type="checkbox"/> T M J WORK UP/SURGERY
<input type="checkbox"/> TORUS REDUCTION
<input type="checkbox"/> TUBEROSITY REDUCTION
<input type="checkbox"/> EXPOSURE OF IMPACTED CUSPID
<input type="checkbox"/> INCISION AND DRAINAGE |
|---|--|---|

REMARKS _____

RADIOGRAPHS ENCLOSED YES _____ NO _____ PLEASE RETURN _____
 REFERRED BY DR. _____ DATE _____