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3360 Northdale Blvd NW, Coon Rapids, MN 55448

Date _____

Patient Name _____

Phone _____

For:

- ❑ Extractions
- ❑ Alveoloplasty
- ❑ Biopsy
- ❑ Facial Pain
- ❑ Implants
- ❑ Panorex
- ❑ Sleep Apnea
- ❑ Trauma/Facial Fractures
- ❑ Orthognathic Evaluation/Treatment
- ❑ Radiation Therapy Oral Evaluation
- ❑ TMJ Evaluation/Treatment
- ❑ Pre-prosthetic Evaluation/Treatment
- ❑ Pathology Consultation
- ❑ Facial and Cosmetic Surgery

Remarks: _____

_____

				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		
RIGHT	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	**LEFT**	
				T	S	R	Q	P	O	N	M	L	K					

PATIENTS HAVING INTRAVENOUS SEDATION (patient asleep)
MUST NOT HAVE any food or fluids for six hours before surgery, and
MUST HAVE an adult accompany them and remain in the office.

Appointment Date _____ Time _____

Referring Doctor _____

Referring Practice _____

Email _____

Phone _____

Fax _____

TDS THE DENTAL SPECIALISTS

ORAL & MAXILLOFACIAL SURGERY