



# EASTERN VIRGINIA

ORAL & MAXILLOFACIAL SURGERY

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PATIENT'S NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

PHONE: \_\_\_\_\_

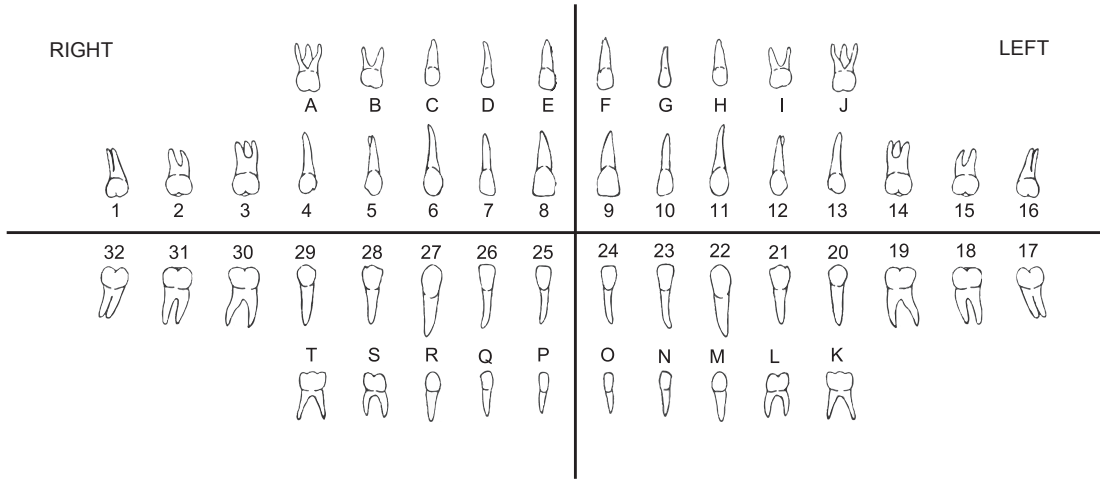
REFERRED BY: \_\_\_\_\_

OFFICE PH#: \_\_\_\_\_

### REASON FOR REFERRAL:

- Extraction (see below)
- Socket Bone Graft
- Implants (see below)
- Exposure/Bonding
- Pre-Prosthetic
- Apicoectomy
- Infection/I & D
- Frenectomy
- Biopsy/Pathology
- TMD
- Orthognathic Surgery
- Trauma
- Sleep Apnea
- Other \_\_\_\_\_

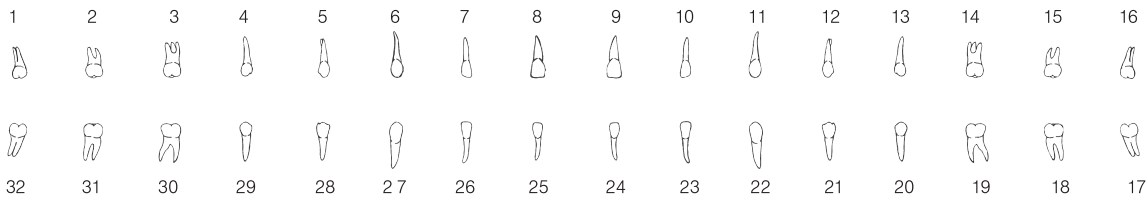
### Please Mark Teeth To be Extracted



Please Verify Tooth Number \_\_\_\_\_

### IMPLANT EVALUATION

#### Please Indicate Implant Site



Preferred Implant:  Nobel  Straumann  Biohorizon

Comments: \_\_\_\_\_