VALLEY ORAL & MAXILLOFACIAL SURGERY

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DATE: Patient Name: DOB:	REFERRING DOCTOR NAME: NPI#: Phone #:
☐ New Patient ☐ Established Patient	Appointment Date:
Phone Number:	☐ X Ray Date: Taken:

UPPER TEETH

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

RIGHT LOWER TEETH LEFT

UPPER TEETH

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

RIGHT LOWER TEETH LEFT

Referring By: ☐ Dentist ☐ Physician

SIGNATURE OF REFERRING DOCTOR

COMMENTS: