



**eastern maryland**

oral & maxillofacial surgery

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Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Referring Dentist: \_\_\_\_\_

**Please circle teeth to be treated**

UPPER RIGHT								UPPER LEFT							
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
LOWER RIGHT								LOWER LEFT							

**Deciduous**

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

Consultation/Procedure

- Wisdom Teeth
- Extraction
- Bone Graft
- Implant
- Expose and Bond
- Biopsy
- Alveoplasty / Tori
- Sinus Augmentation
- Frenectomy

Special Instructions:

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Xray (Circle one):

Emailed

Faxed

Given to Patient

Please take

Welcome to the Office of Eastern Maryland Oral and Maxillofacial Surgery

Please note that the first visit, with the exception of certain emergencies, consists of a consultation only. This enables our doctors to fully review your health history, evaluate your problem and determine the most appropriate approach for anesthesia and treatment. Patients under the age of 18 must be accompanied by a parent or legal guardian at the time of the appointment. Please bring all pertinent medical information, a list of all medications, this referral form and X-ray.