EASTERN VIRGINIA
ORAL & MAXILLOFACIAL SURGERY

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PATIENT'S NAME: _____

DOB: _____

PHONE: _____

PATIENT EMAIL: _____

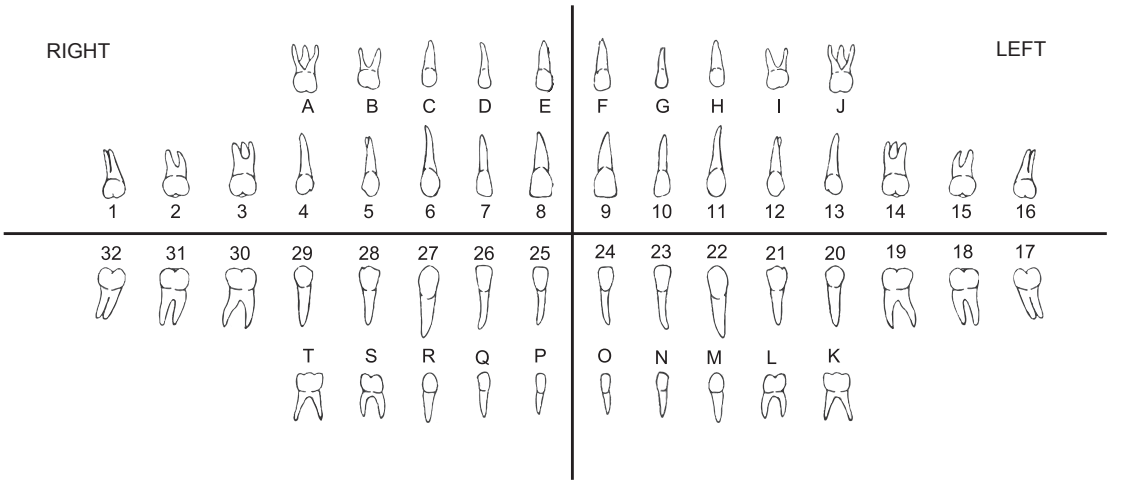
REFERRED BY: _____

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 _____

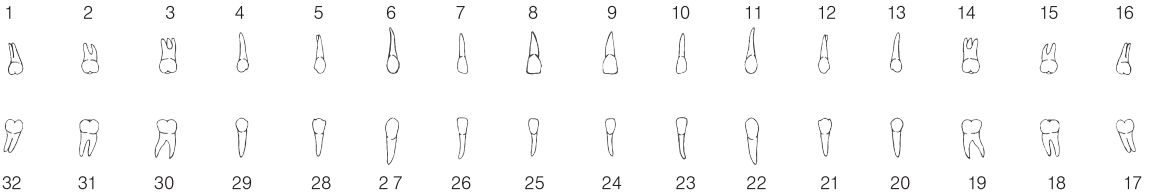
Please Mark Teeth To be Extracted



Please Verify Tooth Number_____

IMPLANT EVALUATION

Please Indicate Implant Site



Preferred Implant: ❑ Straumann ❑ Biohorizon

Comments: _____

_____