DR. GRAHAM GRABOWSKI
ORAL & MAXILLOFACIAL SURGEON
CERTIFIED SPECIALIST

Date: _____ Patient Name: _____

Patient Cell: _____ Patient Email: _____

Patient Birth Date: ____/___/_____ Patient Other Phone: _____
(DD) / (MM) / (YYYY)

Patient Insurance Info: _____

Referring Doctor: _____ Doctor Phone: _____

☐ Third Molars ☐ Dental Extraction(s) ☐ Bone Augmentation
☐ Implant(s), Location: _____
☐ Tooth exposure ☐ Pathology / Biopsy ☐ Orthodontic Implant
☐ Alveolar Cleft ☐ Facial Trauma
☐ Sedation ☐ Other: _____

Teeth to be extracted:

			55	54	53	52	51	61	62	63	64	65			
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
			85	84	83	82	81	71	72	73	74	75			

99 - Supernumerary, Qty: Other:

Radiographs: ☐ Mailed ☐ E-mailed ☐ Enclosed ☐ With Patient ☐ Please obtain

Notes: _____

_____

_____

_____

Medical Alert: _____

Signature: _____

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