David W. Barnett, DDS, MD
Oral and Maxillofacial Surgery

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Date:_____

Introducing:_____
FIRST NAME **LAST NAME**

Referred by:_____

Permanent

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

Primary

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

Please evaluate for extraction of tooth number(s):

_____

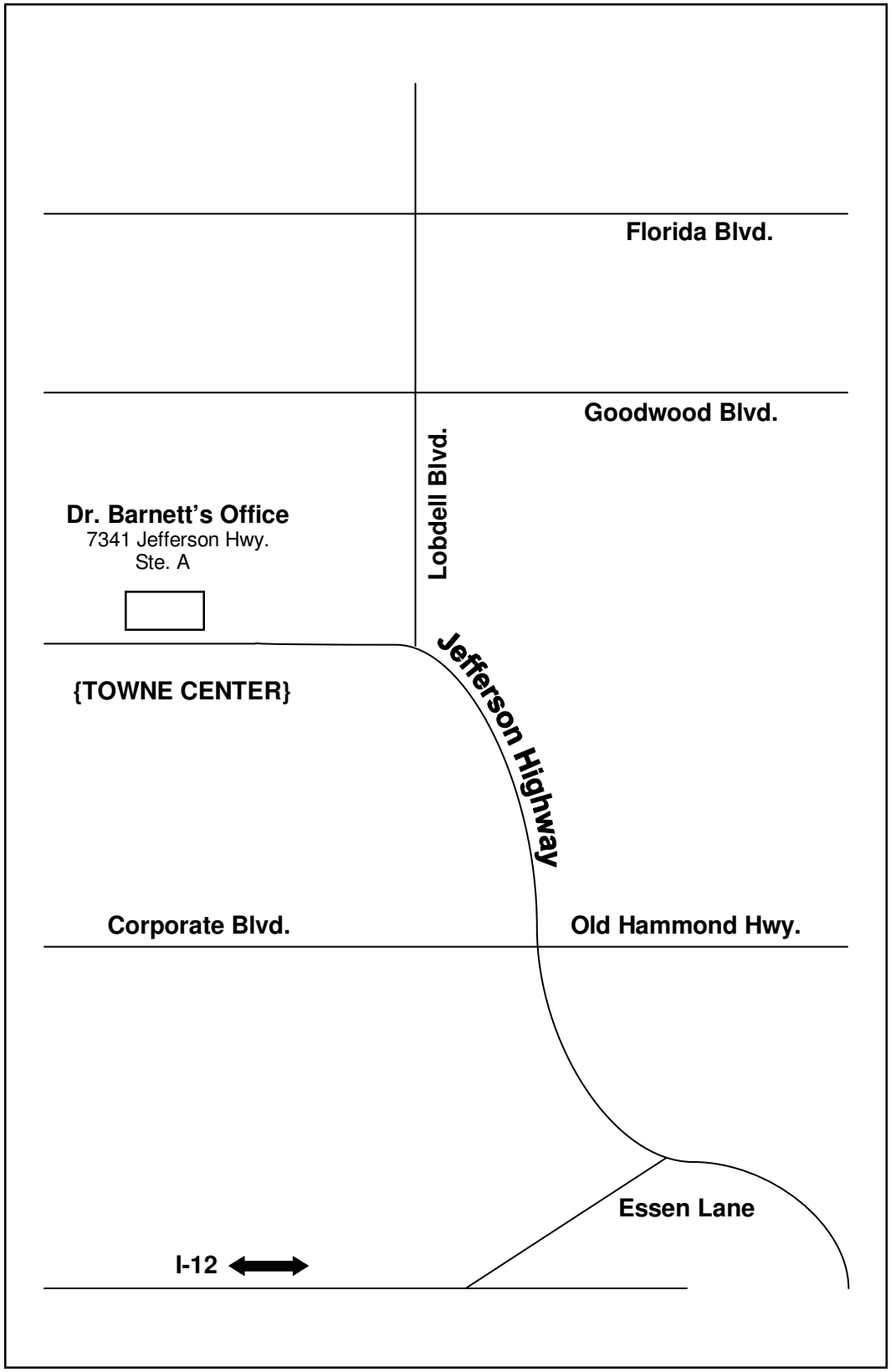
Please evaluate for implant(s) to replace tooth number(s):

_____

Please evaluate and treat the following condition(s):

Radiographs: ☐ **with patient** ☐ **to be mailed** ☐ **please obtain**

Location map on reverse side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