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www.eastcountyoralsurgery.com

Email to: info@eastcountyoralsurgery.com

Date _____

Patient's Name _____ DOB _____

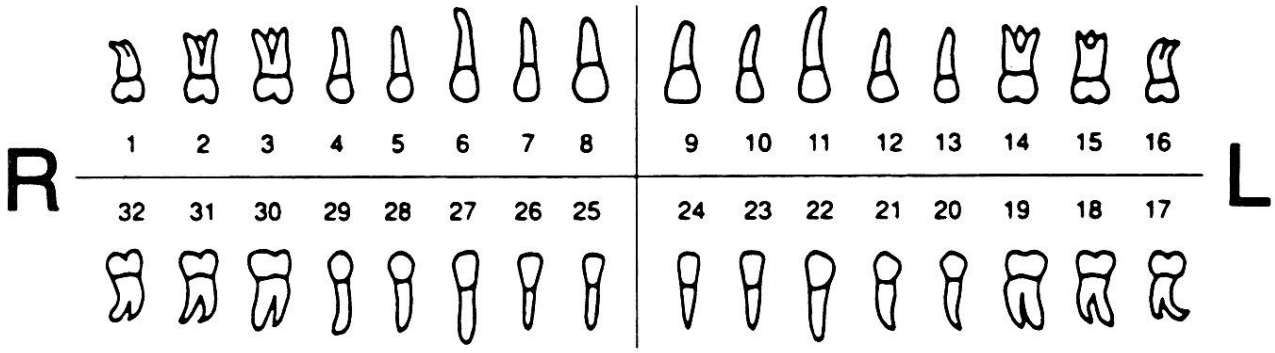
Address _____

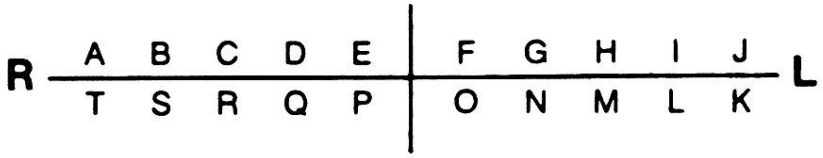
City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

PLEASE MARK (X) FOR EXTRACTION





Radiographs: **Please email to: info@eastcountyoralsurgery.com**

☐ Are needed ☐ Are enclosed ☐ Accompanying patient

Study Models: ☐ Completed ☐ Given to pt ☐ Needed

Please examine for: ☐ Implants ☐ TMJ ☐ Pre-prosthetics ☐ Orthognathic Surgery
☐ Pre-Orthodontics ☐ Pathology ☐ Other

Remarks _____

_____

_____

_____

PLEASE SEND: ( ) REFERRAL SLIPS

☐ An appointment has been scheduled for _____ at _____

DR. _____ **PHONE** _____