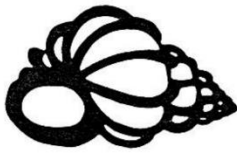


Roberto J. Deloso, DDS Matthew K. Chroust, DDS, MD Alex Romash, DDS, MD



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www.eastcountyoralsurgery.com

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Date _____

Patient's Name _____ DOB _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

PLEASE MARK (X) FOR EXTRACTION

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
R	A	B	C	D	E	F	G	H	I	J	L						
	T	S	R	Q	P	O	N	M	L	K							

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** _____