sunrise
ORAL AND MAXILLOFACIAL
SURGERY CENTER

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Date: _____

Patient Name: _____

Referred By: _____

◯ Extraction ◯ Implant Evaluation ◯ Other

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

Remarks: _____

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