



BOULDER VALLEY

ORAL & MAXILLOFACIAL SURGERY

Patient _____ Date _____

PLEASE CIRCLE TEETH REQUIRING TREATMENT

Right

Left

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

- | | |
|---|------------------------------------|
| <input type="checkbox"/> EXTRACTIONS | <input type="checkbox"/> PATHOLOGY |
| <input type="checkbox"/> PREPROSTHETIC SURGERY | <input type="checkbox"/> IMPLANTS |
| <input type="checkbox"/> ORTHOGNATHIC SURGERY | <input type="checkbox"/> BIOPSY |
| <input type="checkbox"/> UNCOVERING OF IMPACTED TOOTH | <input type="checkbox"/> INFECTION |

Comments

Dr. _____ Phone _____

Thao T. Le, D.D.S., M.D.

1840 Folsom Street, Suite #304 | Boulder, Colorado 80302
 Phone (303) 449-9840 | Fax (303) 545-9712
www.bouldervalleyoms.com