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Patient's Name _____ Date _____

Referring Doctor _____

Appointment: Day Date Time

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

- Orthognathic Surgery Orthodontic Diagnosis/Treatment Plan _____
- Facial Pain, Temporomandibular Dysfunction
- Pathology
- Trauma
- Radiographic Services:
Panoramic_____ Cephalometric_____ Cone Beam CT Scan_____