



**Southern California Center**  
for Oral & Facial Surgery

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www.sccofs.com

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Referred by: \_\_\_\_\_

PLEASE INDICATE TEETH TO BE TREATED OR EXTRACTED:

Permanent

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

Deciduous

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

Consultation and Treatment Instructions: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

X-RAYS SENT: \_\_\_\_\_

SIGNED: \_\_\_\_\_

CIRCLE NAME FOR DOCTOR PREFERENCE

- MAP ON BACK -

White - Patient's Copy

Yellow - Referring Doctor's Copy

White card - Mail to our Office