OCONEE COUNTY
Oral and Maxillofacial Surgery

TODAY'S DATE _____ FROM DR. _____

PATIENT _____
First Name Last Name

AGE _____ TELEPHONE _____

PLEASE MARK AREA FOR TREATMENT

			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			

____ Wisdom Teeth Removal

____ Extraction

____ Bone/Soft Tissue Grafting

____ Orthognathic Surgery Evaluation

____ Other: _____

____ Expose & Bond

____ Dental Implants

____ Pre-Prosthetic Surgery

____ Pathology/Biopsy

____ IV Sedation/Anesthesia

REMARKS: