CHERRY ORCHARD
ORAL & IMPLANT SURGERY

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Patient Name: _____ **Phone:** _____

Appt. Date: _____ **Appt. Time:** _____

☐ Extraction ☐ Orthodontic Exposure ☐ Pathology ☐ Other
☐ Implant ☐ Orthognathic Surgery ☐ TMJ Consult _____

☐ Denture or Partial Involved ☐ Interested in Sedation

RIGHT			A	B	C	D	E	F	G	H	I	J			**LEFT**
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			

Remarks: _____

_____

_____

_____

_____

Referring Doctor: _____ **Date:** _____

In the event that sedation or anesthesia is scheduled the same day as consultation, patient **MUST NOT EAT OR DRINK SIX (6) HOURS** prior to their appointment and be accompanied by a responsible adult to drive.