2315 N. Bechelli Lane, Suite A
Redding, CA 96002

Phone (530) 223-6000
Fax (530) 605-3206

office@reddingoms.com

Patient Contact Information

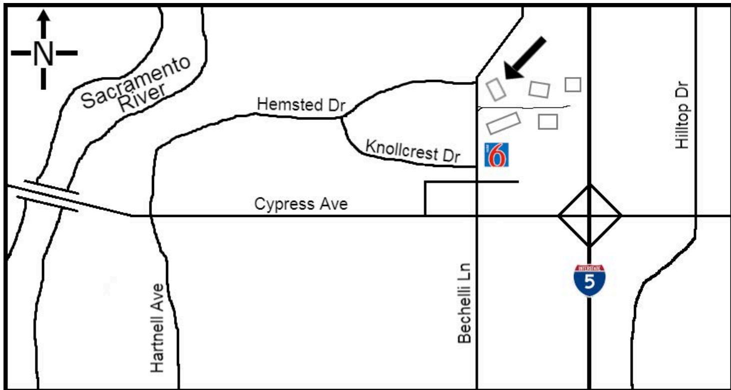
Name: ______________________________ DOB: _____/_____/_____

Phone Number: (_______) ________ – _____________

Email Address: ____

Referring Doctor:____________________ Date: _____/_____/_____

Referring Office:____



Please Circle The Teeth To Be Extracted

Right															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

Deciduous

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

Other Procedures *(Please Check Box)*

- ❑ Dental Implants
- ❑ Expose & Bond
- ❑ Alveoplasty
- ❑ Frenectomy
- ❑ Removal Hypertrophic tissue
- ❑ Tori Removal Max/Mand
- ❑ Incision & Drainage
- ❑ Full Mouth Extraction and Insert Immediate Dentures
- ❑ Lesion Evaluation, Biopsy
- ❑ Other

Indicate Desired Procedure Or Special Instructions: __________

____

____

____

____

____