CLE
Oral & Maxillofacial Surgery, Inc.

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Thomas P. Murphy, D.D.S.

PATIENT'S NAME _____

REFERRED BY _____

DATE REFERRED _____

PLEASE INDICATE TREATMENT OR CONSULTATION DESIRED:

UPPER

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

LOWER

- ☐ CONSULTATION
- ☐ EXTRACTION - ROUTINE
- ☐ EXTRACTION - SURGICAL
- ☐ PANOREX - TMJ XRAY
- ☐ IMPACTION
- ☐ LOCAL ANESTHESIA
- ☐ INHALATION ANESTHESIA
- ☐ INTRAVENOUS ANESTHESIA
- ☐ BIOPSY
- ☐ ALVEOPLASTY
- ☐ APICOECTOMY & ROOT CANAL OR RETROGRADE
- ☐ REMOVAL OF HYPERTROPHIED TISSUE
- ☐ OTHER
- ☐ VESTIBULE EXTENSION & TISSUE GRAFT
- ☐ REMOVAL OF TORUS
- ☐ IMMEDIATE DENTURE PLACEMENT
- ☐ FRENECTOMY - FRENOPLASTY
- ☐ INCISION DRAINAGE
- ☐ EXPOSURE OF UNERUPTED TOOTH
- ☐ SINUS REPAIR
- ☐ DENTAL IMPLANT
- ☐ ENUCLEATION OF CYST
- ☐ TUBEROSITY REDUCTION
- ☐ LASER SURGERY
- ☐ FACIAL PAIN EVALUATION

COMMENTS: _____

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TOP COPY – REFERRING DOCTORS FILE **BOTTOM COPY – PATIENT COPY**