



CLE
Oral & Maxillofacial
Surgery, Inc.

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Michael C. Shapiro, D.D.S., M.A., CAGS

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					T	S	R	Q	P	O	N	M	L	K			L
		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
		LOWER															

- | | |
|---|---|
| <input type="checkbox"/> CONSULTATION | <input type="checkbox"/> VESTIBULE EXTENSION & TISSUE GRAFT |
| <input type="checkbox"/> EXTRACTION - ROUTINE | <input type="checkbox"/> REMOVAL OF TORUS |
| <input type="checkbox"/> EXTRACTION - SURGICAL | <input type="checkbox"/> IMMEDIATE DENTURE PLACEMENT |
| <input type="checkbox"/> PANOREX - TMJ XRAY | <input type="checkbox"/> FRENECTOMY - FRENOPLASTY |
| <input type="checkbox"/> IMPACTION | <input type="checkbox"/> INCISION DRAINAGE |
| <input type="checkbox"/> LOCAL ANESTHESIA | <input type="checkbox"/> EXPOSURE OF UNERUPTED TOOTH |
| <input type="checkbox"/> INHALATION ANESTHESIA | <input type="checkbox"/> SINUS REPAIR |
| <input type="checkbox"/> INTRAVENOUS ANESTHESIA | <input type="checkbox"/> DENTAL IMPLANT |
| <input type="checkbox"/> BIOPSY | <input type="checkbox"/> SUBPERIOSTEAL IMPLANT |
| <input type="checkbox"/> ALVEOPLASTY | <input type="checkbox"/> FACIAL FRACTURE REPAIR |
| <input type="checkbox"/> APICOECTOMY & ROOT CANAL OR RETROGRADE | <input type="checkbox"/> MAXILLARY OSTEOTOMY |
| <input type="checkbox"/> ENUCLEATION OF CYST | <input type="checkbox"/> MANDIBULAR OSTEOTOMY |
| <input type="checkbox"/> TUBEROSITY REDUCTION | <input type="checkbox"/> GENIOPLASTY |
| <input type="checkbox"/> REMOVAL OF HYPERTROPHIED TISSUE | <input type="checkbox"/> FACIAL PAIN EVALUATION |
| <input type="checkbox"/> NERVE REPAIR (MICROSCOPIC) | <input type="checkbox"/> TMJ EVALUATION - SURGERY |
| <input type="checkbox"/> LASER SURGERY | <input type="checkbox"/> OTHER |

COMMENTS: _____

TOP COPY - REFERRING DOCTORS FILE BOTTOM COPY - PATIENT COPY