



CLE
Oral & Maxillofacial
Surgery, Inc.

**AMHERST ORAL SURGERY &
IMPLANT CENTER**

Liberty Woods
550 Leavitt Road • Amherst, Ohio 44001
Telephone 440.988.3400

Erik Warren, D.D.S., M.D.

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																	

- | | |
|---|---|
| <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: _____

