Edward H. Christensen, DDS
Oral and Maxillofacial Surgery
Board Certified

ORAL AND MAXILLOFACIAL ASSOCIATES
of ARIZONA, PLC

Patient Name: _____ Date of Appointment: _____

Right															Left
			A	B	C	D	E	F	G	H	I	J			
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			

Referred for: _____

- ☐ Extraction (mark correct teeth above)
- ☐ TMJ Evaluation
- ☐ Orthognathic Evaluation
- ☐ Fracture Evaluation
- ☐ Lesion Evaluation
- ☐ Dental Implant Consultation
- ☐ Bone Grafting
- ☐ Soft Tissue Grafting
- ☐ Expose/Bond and Bracket
- ☐ Crown Lengthening

Other: _____

- ☐ X-ray emailed to: xray@omaarizona.com
- ☐ X-ray sent with patient
- ☐ X-ray needed

Description:

_____

_____

_____

Referring Doctor: _____ Date: _____

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