NORTH FLORIDA
ORAL & FACIAL SURGERY

☐ SCOTT R. SKLENICKA, D.M.D., M.D.
☐ JOHN J. MAZZUOCCOLO, D.M.D., M.D.
☐ THOMAS R. FARRELL IV, D.D.S.
☐ TYLER M. WAHL, D.M.D.
☐ ASHER B. ADAMEC, D.M.D., M.D.

Date Referral Made: _____

Patient's Name: _____

Patient Phone #: _____

Referred by Dr. _____

For Patients Desiring IV Sedation/General Anesthesia, a Separate Consultation Appointment is REQUIRED.

Please check needed consultation / treatment

_____ Wisdom Teeth
_____ Oral Pathology / Medicine
_____ Expose and Bond # _____
_____ Other: _____

_____ Extraction _____ Socket graft
_____ Dental Implants
_____ Bone graft

DECIDUOUS TEETH

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

Circle teeth to be removed:

	Molars			Bicuspids		Anteriors						Bicuspids		Molars			
R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Remarks: _____

_____

_____

X_____
Doctor's Signature required

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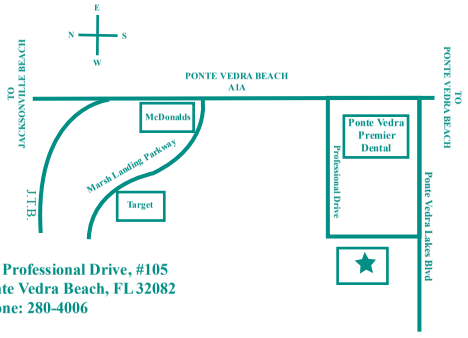

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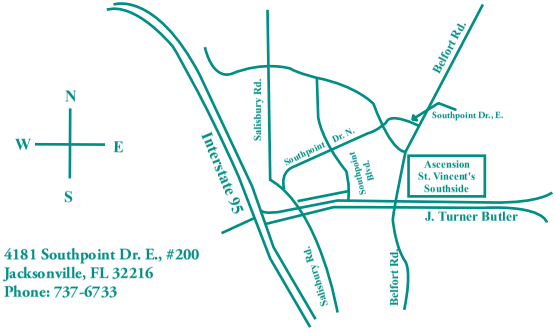

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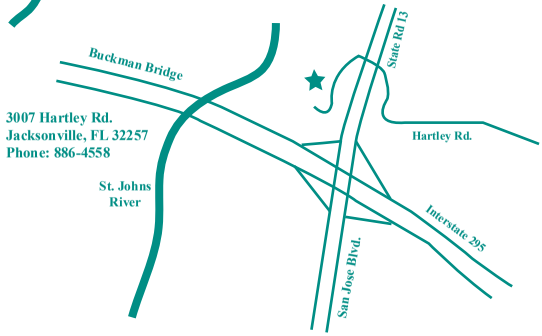

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