Legacy Surgery

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Patient Name ______________________ Today's Date __________

Patient Phone ______________________ Date of Birth __________

Patient Email ______________________

Referred by ______________________

X-Rays Enclosed? ( ) Yes, Date Taken __________ ( ) No, please take X-Rays

MARK TEETH FOR REMOVAL:

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 ——— DECIDUOUS ——— 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

REQUESTED CONSULTATION:

( ) Dental Implants
( ) Full Arch Hybrid
( ) Wisdom Teeth Removal
( ) Dental Extraction
( ) Exposure/Bond
( ) Alveoloplasty
( ) Other __________

IMPLANT PREFERENCES:

( ) Impression Coping & Analog: ___ Closed ___ Open
( ) Custom Tissue Former / Immediate Temporization
( ) Digital STL File

ADDITIONAL REMARKS: ______________________

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