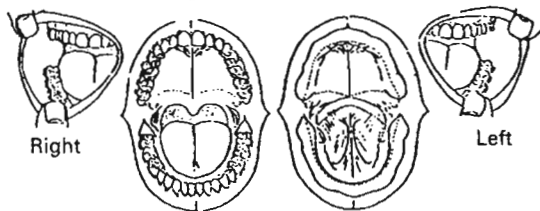


Soft Tissue Chart



Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Phone: \_\_\_\_\_

Referred by:

**Special Instructions for Patients**

Day of surgery...

- 1.) No food or drink eight (8) hours prior.
- 2.) Provide transportation.
- 3.) Under eighteen (18) must be accompanied by an adult.

CONSULTATION:

- |  |  |
|--|--|
| <input type="checkbox"/> Extraction (mark above) | <input type="checkbox"/> Implants                |
| <input type="checkbox"/> Alveoplasty             | <input type="checkbox"/> Pre-Prosthetic          |
| <input type="checkbox"/> Lesion                  | <input type="checkbox"/> Orthognathic Evaluation |
| <input type="checkbox"/> Incision & Drainage     | <input type="checkbox"/> Bone Grafting           |
| <input type="checkbox"/> RPE                     | <input type="checkbox"/> Ridge Augmentation      |
| <input type="checkbox"/> Apicoectomy             | <input type="checkbox"/> Facial Cosmetic Surgery |
| <input type="checkbox"/> Biopsy                  | <input type="checkbox"/> Frenectomy              |
| <input type="checkbox"/> Fiberotomy              | <input type="checkbox"/> Expose & Bond           |

RADIOGRAPHS:

- |   |
|---|
| <input type="checkbox"/> Being Mailed     |
| <input type="checkbox"/> Given To Patient |
| <input type="checkbox"/> Please Take      |
| <input type="checkbox"/> No X-Ray         |
| <input type="checkbox"/> Will Bring X-Ray |

---



---



---

Our office is located on the map below.

Our office staff will gladly provide additional directions for your travel to our office.

