Jennifer Okhiria, DDS FACS
Diplomate of the American Board of Oral and Maxillofacial Surgery
470-944-1881
470-401-6021
www.buckheadoralsurgerysuite.com
info@buckheadoralsurgerysuite.com
1800 Peachtree Rd. NW #850, Atlanta, Ga 30309

BUCKHEAD
ORAL SURGERY SUITE

Date: _____

Patient Name: _____

Patient Phone: _____

Referring Doctor: _____

Please circle teeth involved:

			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
R																L
	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			

X-Rays:

- ☐ Mailed
- ☐ E-mailed
- ☐ Sent with patient
- ☐ Please take x-rays

Referred for:

- ☐ Wisdom Teeth
- ☐ Tooth Extraction
- ☐ Bone Grafting
- ☐ Dermal Fillers
- ☐ Ridge/Sinus Augmentation
- ☐ Implant
- ☐ All-on-X
- ☐ Expose and Bond
- ☐ Botox
- ☐ Pre-prosthetic Surgery
- ☐ Frenectomy
- ☐ TMJ Disorder
- ☐ Biopsy/Pathology
- ☐ Facial Trauma
- ☐ Reconstruction
- ☐ CBCT

Additional Comments: _____

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