



Glen Burnie Oral Surgery Associates Dental Implant Center

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Patient Name: _____

Referring Dr. _____ Date: _____

Procedure

- | | | | |
|--|---|--|--|
| ☐ Extractions | ☐ Alveoplasty | ☐ Exposure & Bond | ☐ Torus Removal |
| ☐ Bone Grafting | ☐ 3D Cone Beam | ☐ Crown Lengthening | ☐ Frenectomy |
| ☐ Radiograph | ☐ Sinus Augmentation | ☐ Ridge Augmentation | ☐ Implants |
| ☐ Biopsy | ☐ TMJ | ☐ Incision & Drainage | ☐ IV Sedation |

Extractions

1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16
Upper Right	Upper Left
A B C D E	F G H I J
Lower Right	Lower Left
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

Please mark proposed extraction site

Auxiliary procedures requested

Implants

2 3 4 5 6 7 8 9 10 11 12 13 14 15
31 30 29 28 27 26 25 24 23 22 21 20 19 18

Please shade proposed implant site

Preferred Implant

☐ All-On-4

Surgical Template

- ☐ To be provided by restorative dentist ☐ To be fabricated by surgeon
☐ Other _____

Radiographs

- ☐ Being mailed / E-mailed ☐ Hand carried by patient ☐ Please take

**PLEASE NOTE THAT IN MOST INSTANCES THE PATIENT IS FIRST SEEN FOR CONSULTATION
TO REVIEW THE HEALTH HISTORY, DECIDE ON THE MOST APPROPRIATE ANESTHESIA AND TREATMENT
PLAN AND SCHEDULE THE SURGERY AT A SEPARATE APPOINTMENT**