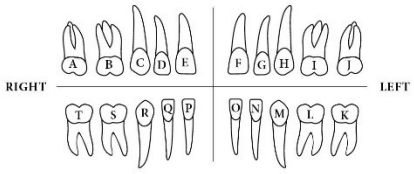
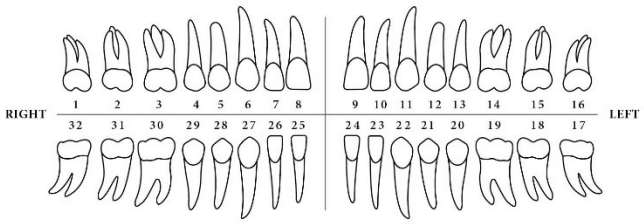
JOHNSON
ORAL FACIAL SURGERY

Patient Name:_____ Referred By:_____

Date: _____ DOB: _____ Phone Number: _____

- □ Extractions
- □ Implants
- □ Pathology
- □ Other _____
- □ Expose and Bond
- □ Bone Grafting
- □ TMJ
- □ Trauma
- □ Cosmetic
- □ Orthognathic





Remarks: _____

_____

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Appointment: _____ Signed: _____