



Derek H. Lamb, D.M.D., M.D.
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Consultation Appointment: This time is reserved specifically for you. If by necessity, you must cancel your appointment, please notify us as soon as possible.

Date: _____ Pt. Phone : _____

Introducing: _____

Referred by: _____

Right					Please circle teeth to be treated										Left																	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	
Deciduous																																
	E	D	C	B	A	A	B	C	D	E													E	D	C	B	A	A	B	C	D	E
	E	D	C	B	A	A	B	C	D	E													E	D	C	B	A	A	B	C	D	E

Extraction

OTHER PROCEDURES (Please indicate below)

- Alveoplasty
- Biopsy
- Frenectomy
- Infection

- Apicoetomy
- Lesion Evaluation
- Incision & Drainage
- Exposure

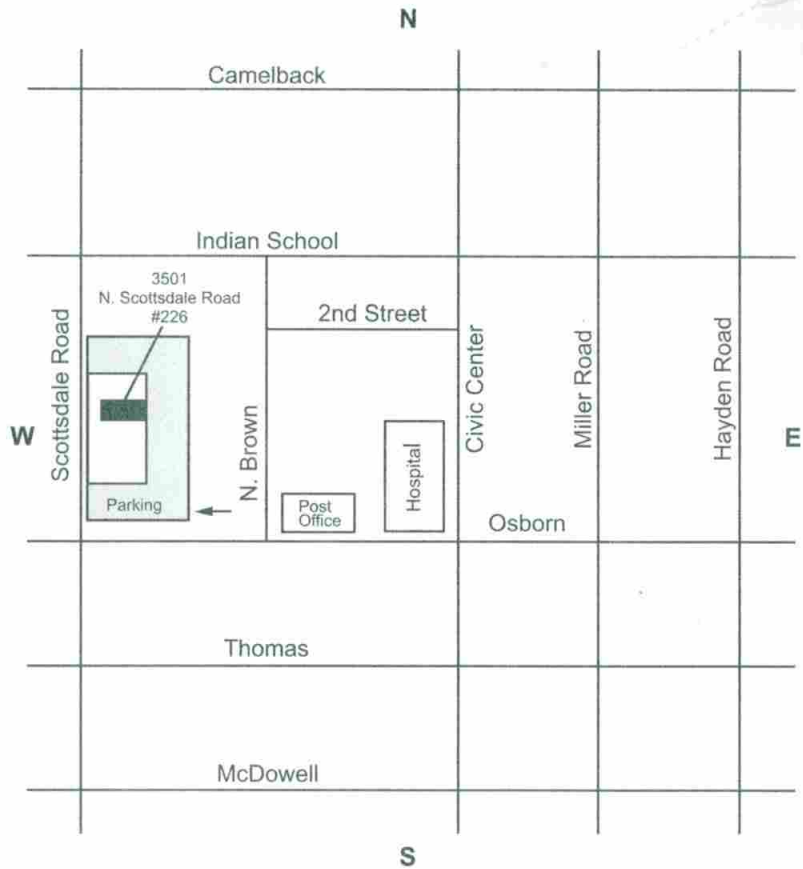
RADIOGRAPHS

- Being Mailed
- Given to patient
- Please Take
- No X-ray

CONSULTATION

- Orthognatic evaluation
- Implants

Special Instructions: _____



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THE CENTER FOR DENTAL IMPLANTS
RECONSTRUCTIVE ORAL & MAXILLOFACIAL SURGERY

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