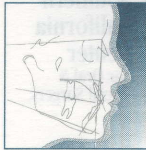

Southern California Center for Oral & Facial Surgery

Jay B. Reznick, D.M.D., M.D.
Diplomate, American Board of Oral and Maxillofacial Surgery

Susan J. Lee, D.M.D., M.D.
Diplomate, American Board of Oral and Maxillofacial Surgery

18372 Clark Street, Suite 224 • Tarzana, California 91356
Ph: (818) 996-1200 • Fax: (818) 996-1325
www.sccofs.com

Date: ________________

Patient's Name: ______________________________ Age: __________

Address: ____

______________________________ Telephone: ______________

Referred by: ____

PLEASE INDICATE TEETH TO BE TREATED OR EXTRACTED:

Permanent

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Deciduous

R

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

L

Consultation and Treatment Instructions: ______________________

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____

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COMMENTS: ______________________________________

____

____

____

X-RAYS SENT: ___________________________________

SIGNED: _______________________________________

CIRCLE NAME FOR DOCTOR PREFERENCE

- MAP ON BACK -

White - Patient's Copy *Yellow - Referring Doctor's Copy* *White card - Mail to our Office*