

VISTA**Med**

Oral and Maxillofacial Surgery

David Smith, DDS, MD

PATIENT NAME: _____

REFERRAL DATE: _____

REFERRED BY: _____

Please circle teeth to be treated

UPPER RIGHT								UPPER LEFT							
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
LOWER RIGHT								LOWER LEFT							

Deciduous

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

Consult/Procedure:

- Extraction(s) # _____
- Implant(s) # _____
- Bone Grafting
- Biopsy
- Other: _____

***Radiographs-Please email patient's
X-ray prior to appointment**

Email to info@vistamedos.com

Special Instructions:

Welcome to VISTAMed Oral and Maxillofacial Surgery
**Patients under the age of 18 must be accompanied by a parent or legal guardian at the time of appointment. Please bring all pertinent medical information and a list of all medications.*

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