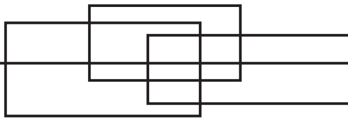

Middleton Oral Surgery

Scott Middleton, DMD, MD

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Patient Name________________________________ Date ________________

Referred by Dr.____

Phone________________________ To be contacted by office? ☐ YES ☐ NO

Patient Email ____ (for paperwork)

Remarks ____

____

____

Radiographs ☐ Mailed ☐ Emailed ☐ Given to Patient ☐ Please Take

				A	B	C	D	E	F	G	H	I	J				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R																	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
				T	S	R	Q	P	O	N	M	L	K				

☐ Extract Indicated Teeth

☐ Dental Implant Evaluation

☐ Bone Graft Evaluation

☐ Other ____

☐ Torus Removal

☐ TMJ Evaluation

☐ Oral Pathology

PLEASE NOTE THAT WITH THE EXCEPTION OF CERTAIN EMERGENCIES, THE FIRST VISIT IS FOR **CONSULTATION ONLY**. THIS ALLOWS DR. MIDDLETON TO REVIEW YOUR HEALTH HISTORY AND DETERMINE THE MOST APPROPRIATE ANESTHESIA AND TREATMENT PLAN FOR YOU. SURGERY IS SCHEDULED FOR A SEPARATE APPOINTMENT. PLEASE BRING ALL PERTINENT MEDICAL INFORMATION, THIS REFERRAL, AND A LIST OF CURRENT MEDICATIONS.