Craig Mangie, DDS
Oral and Maxillofacial Surgery
Section of Dentistry

Date: _____

Patient Name: _____ Date Referred: _____

Patient DOB_____ Patient Phone Number: _____

Referring Dentist: _____ Dentist Phone Number: _____

- ☐ Consultation
- ☐ Extraction-Routine
- ☐ Panorex-TMJ xray
- ☐ Impaction
- ☐ Local Anesthesia
- ☐ Intravenous Anesthesia
- ☐ Biopsy
- ☐ Alveoplasty
- ☐ Apicoectomy & Root Canal or Retrograde
- ☐ Removal of Hypertrophied Tissue
- ☐ Removal of Torus
- ☐ Frenectomy-Frenoplasty
- ☐ Incision Drainage
- ☐ Exposure of Unerupted Tooth
- ☐ Sinus Repair
- ☐ Dental Implant
- ☐ Enucleation of Cyst
- ☐ Tuberosity Reduction
- ☐ Orthognathic Surgery
- ☐ Other

Comments_____

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Please email any current radiographs including recent full mouth series or panoramic films within the past 5 years to **dentalimages@ccf.org**

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Head and Neck Institute

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