

North Port Oral Surgery & Dental Care

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Patient Phone # _____

Introducing _____

Referring Dr. _____ Date _____

Removal of Teeth

Bone Grafts

Alveoloplasty

IV Anesthesia

Please Remove:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

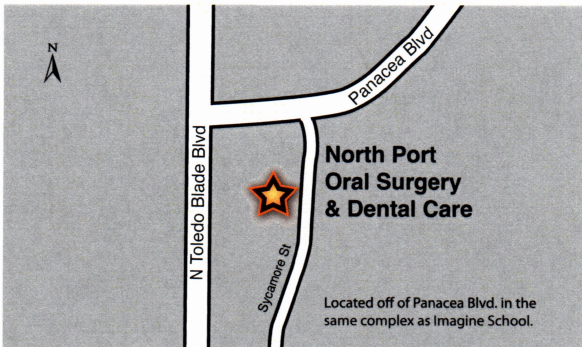
 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Right

Left

a b c d e f g h i j

 t s r q p o n m l k



Instructions _____
