JACKSON ORAL SURGERY

Walter C. Jackson, DDS, MD
Board Certified Oral & Maxillofacial Surgeon

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PATIENT NAME ____

APPOINTMENT DATE ____________________ TIME ____________________

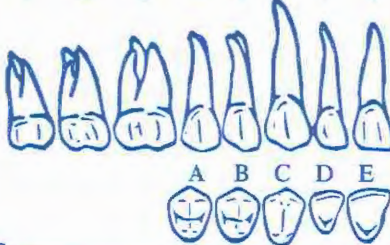
REASON FOR REFERRAL (please circle):

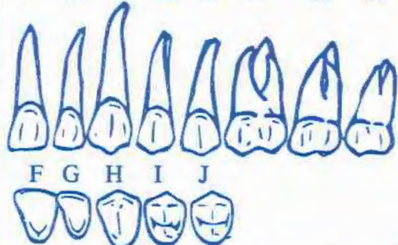
Dental Implants | Extractions

Wisdom Teeth | Biopsy

IV Sedation | Expose and Bracket

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





A B C D E | F G H I J

RIGHT —————————————————— LEFT

T S R Q P | O N M L K

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

REMARKS ____

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DOCTOR ____________________ DATE ____________________