Appointment:____/____/____
Time: ________
Office: LC/PAS/GLN

ORAL & MAXILLOFACIAL SURGERY ~ DENTAL IMPLANTS

www.foothilldentalimplants.com

1370 Foothill Blvd., #200
La Canada, CA 91011
Telephone (818) 952-8183
FAX (818) 952-6437

212 S. El Molino Ave.
Pasadena, CA 91101
Telephone (626) 792-3161
FAX (626) 792-9442

500 N. Central Ave., #710
Glendale, CA 91203
Telephone (818) 240-1805
FAX (818) 240-2844

Patient Name: ________________________________ ***Date:*** __________________________

Referred by: __________________________________ ***Patient telephone:***________________

Please indicate surgeon of choice:

- ☐ ***Elgan P. Stamper, D.D.S.***
- ☐ ***John L. Lytle, M.D., D.D.S.***
- ☐ ***Robert J. Lytle, D.D.S.***
- ☐ ***No Preference***

Requested evaluation or procedure:

____
____
____
____
____
____

Please indicate areas below:

RIGHT | LEFT

			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**
8	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
8	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
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**			

□ Treatment plan for implants – below.

FOR IMPLANTS ONLY:

Describe problem

____

Treatment Plan

____

Esthetic concerns

____

Surgical Guide: ☐ I will fabricate ☐ Surgeon to fabricate
Crowns: ☐ Cement ☐ Screw retained

****Please fax, e-mail and /or send hard copy.***
info@foothilldentalimplants.com . Please put patient's name in subject line.
Please indicate: □ Faxed □ Emailed