# **Samuel Goodloe III**, DDS, MD. PLLC.

ORAL & MAXILLOFACIAL SURGERY

Diplomate, American Board of Oral & Maxillofacial Surgery

Date: _____

**Introducing:** _____ **Phone:** _____

**Referring Doctor:** _____ **Phone:** _____

I am referring my patient for the following treatment(s) (please check all that may apply):

❑ Extraction(s) _____

❑ Implant Dentistry Consult (location) _____

❑ Emergency Treatment /Infection _____

❑ Bone Graft/Reconstructive Surgery _____

❑ Orthodontic Tooth Exposure(s) _____

❑ Oral Pathology Evaluation /Biopsy Area _____

❑ Pre-Prosthetic Surgery _____

❑ Evaluation of Trauma (location) _____

**Please circle the teeth to be treated:**

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | A | B | C | D | E | F | G | H | I | J | | | |
| **Right** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 **Left** |
| | 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 | | | |

**Recent Radiographs:**

❑ Please take new radiographs ❑ Mailed to your office ❑ Accompanying patient

If you must cancel your appointment, please provide 24 hrs notice to reschedule. Minors (under 18) must be accompanied by a parent/legal guardian to allow a consultation and/or any surgical treatment to be performed.

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