

PLEASE PRINT CLEARLY

PLEASE INDICATE TREATMENT TO BE PERFORMED:

- Extractions
- Implantology / Preprosthetic Surgery
- Pathology consultation/ Biopsy
- Bone Graft Reconstruction
- Facial Trauma
- Consultation

Remarks: CONSULTATION - EXTRACTION
AND IMPLANT # 14 and # 15
check lower left - pls. check
(growth)



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 720 Cowper Street • Palo Alto, CA 94301
 For appointments call (650) 328-6622
 Fax: (650) 618-2717

Appointment:
 Date: _____
 Time: _____ Am/Pm

Today's Date AUGUST 16, 2021
 Introducing: ANDREW SHARP
 Address: _____

Phone No. (650) 906-9448
 Referred By: JOSEPH PARALSO

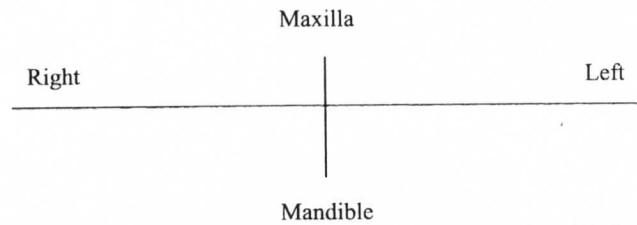
X-RAYS:
 With Patient Sent in mail
 To be taken N/A

Register on the web
 To save time at your appointment, log onto our web page at www.piads.org. Complete the patient registration form and learn more about our office.

EVALUATE FOR EXTRACTION: Please circle teeth

IMPLANTOLOGY: Please indicate sites

(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	
	A	B	C	D	E	F	G	H	I	J							
	T	S	R	Q	P	O	N	M	L	K							



White Copy - Patient

Yellow Copy - Oral Surgeon

Pink Copy - Referring Doctor

See other side for directions →

A Professional Corporation