



Bay State Oral Surgery Associates, Inc

Board Certified Oral and Maxillofacial Surgeons

Oral Surgery and Dental Implants

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www.BayStateOMS.com

Date: _____

Patient's Name: _____

Referring Doctor/Office: _____

Referring Doctor Telephone: _____

For Consideration of The Following

- | | | |
|---|--|--|
| ☐ Extraction of teeth | ☐ Impacted teeth | ☐ Expose and bond |
| ☐ Biopsy/pathology | ☐ Dental implants | ☐ Lesion Evaluation |
| ☐ Pre-prosthetic surgery | ☐ Other: | |

Please Circle Teeth To Be Treated

Permanent Teeth															
Upper Right								Upper Left							
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
Lower Right								Lower Left							

Primary teeth									
Upper Right					Upper Left				
A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K
Lower Right					Lower Left				

Xray: ☐ With Patient ☐ Email ☐ Being Mailed ☐ Please Take

Remarks: _____

1. PLEASE REGISTER PRIOR TO YOUR APPOINTMENT ON OUR WEBSITE AT WWW.BAYSTATEOMS.COM.
2. MINORS **MUST** HAVE A PARENT OR GUARDIAN PRESENT.
3. PLEASE BRING A COMPLETE LIST OF ALL MEDICATIONS.
4. PRIOR TO ANY SURGERY, A CONSULTATION MAY BE REQUIRED.

PLEASE VISIT US @ www.BayStateOMS.com