SoundSurgery
Oral Surgery and Dental Implants

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Date: _____

Introducing: _____ Patient Phone: _____

Referred by Doctor: _____

Appointment Date and Time: _____

Consultation for: _____

_____

_____

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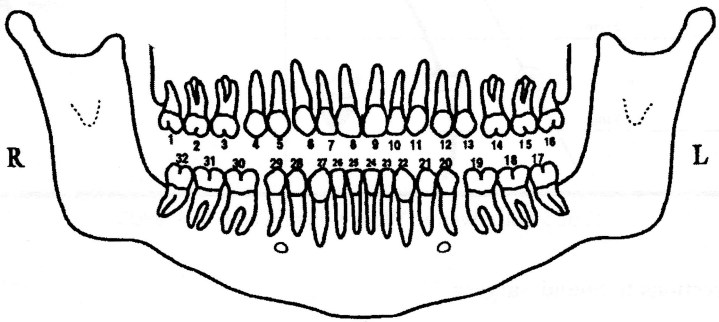
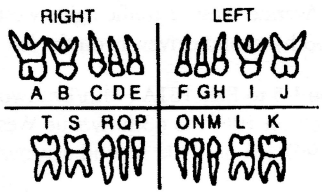
- ○ **Diagnosis / X-Rays**
- ○ **Dental Implants**
- ○ **Pathology**
- ○ **Crown Lengthening**
- ○ **Expose and Bond**
- ○ **Orthognathic Surgery**
- ○ **Extraction of Teeth**





White: Patient Copy **White:** Mail or fax to our office. **Yellow:** Referring Dentist

19625 68th Avenue West • Lynnwood, WA 98036