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Diplomate, American Board of Oral and Maxillofacial Surgery
Specialty permit #06061

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Patient Name:_____

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				

Comments:

____ X ray emailed

Referring Dr. _____ Date _____