KENNETH B. WHITWORTH DDS, MD
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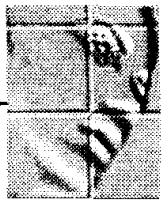

Date _____

Introducing _____ Age _____
Phone (home) _____ (work) _____

Referred by Dr. _____ Phone _____

APPOINTMENT INFORMATION: This time is reserved specifically for you. If for any reason you cannot keep this appointment, please call our office at least 48 hours in advance. There will be a charge for a missed appointment.

DAY _____ **DATE** _____ **TIME** _____

UPPER

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R					A	B	C	D	E	F	G	H	I	J			L
					T	S	R	Q	P	O	N	M	L	K			
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

LOWER

CONSULT:
- ☐ 3rd Molars
- ☐ Implant/Reconstructive
- ☐ Orthognathic

PROCEDURES:
- ☐ Extract, #_____
- ☐ Alveoloplasty
- ☐ Biopsy

- ☐ X-Ray Mailed
- ☐ X-Ray sent with patient
- ☐ Take X-Ray
- ☐ Send more referral slips

REMARKS: _____

_____

DOCTORS COPY
Retain for record of referral