

# TORRI**Med**

Oral Surgery and Dental Implants

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*Oral & Maxillofacial Surgery*

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### ***Appointment***

Patient Name: \_\_\_\_\_

Appointment Date: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

### **Welcome to the office of TorriMed Oral Surgery and Dental Implants**

Please note that the first visit, with the exception of certain emergencies, consists of a consultation only. This enables our doctors to fully review your health history, evaluate your problem and determine the most appropriate approach for anesthesia and treatment. Patients under the age of 18 must be accompanied by a parent or legal guardian at the time of the appointment. Please bring all pertinent medical information and a list of all medications.

### **Please circle teeth to be treated**

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							

### **Deciduous**

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

### **Consultation/Procedure**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Extraction         | <input type="checkbox"/> Orthognathic    | <input type="checkbox"/> Implants      |
| <input type="checkbox"/> Torus Removal      | <input type="checkbox"/> Expose and Bond | <input type="checkbox"/> Bone grafting |
| <input type="checkbox"/> Sinus Augmentation | <input type="checkbox"/> Infection (I&D) | <input type="checkbox"/> Frenectomy    |
| <input type="checkbox"/> Biopsy             | <input type="checkbox"/> TMJ             | <input type="checkbox"/> Alveoplasty   |

### **Radiographs:**

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Mailed/Emailed | <input type="checkbox"/> Given to patient | <input type="checkbox"/> Please Take |
|---|---|--------------------------------------|

### **Special instructions:**

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