

**John A. Boghossian, D.D.S., Inc.**

*Diplomate, American Board of Oral & Maxillofacial Surgery*

1650 Laurel Street, Suite B • San Carlos, CA 94070

(650) 595-0163 • Fax (650) 595-0256

Date \_\_\_\_\_

**Introducing**

\_\_\_\_\_ **for Consultation.**

Patient's Telephone # \_\_\_\_\_

Appointment Date \_\_\_\_\_ Time \_\_\_\_\_ AM  
PM

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

X-rays:  Attached  Sent in mail  To be taken  Email

Please indicate Areas or Teeth to be Evaluated for Treatment

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

**Consultation For:**

- |   |   |
|---|---|
| <input type="checkbox"/> Impaction(s)                     | <input type="checkbox"/> Orthodontic Exposure   |
| <input type="checkbox"/> Extraction(s)                    | <input type="checkbox"/> Orthognathic   |
| <input type="checkbox"/> Implant (s)                      | <input type="checkbox"/> Frenectomy/Fiberotomy  |
| <input type="checkbox"/> Pathology/Biopsy/Brush Biopsy    | <input type="checkbox"/> Soft Tissue/<br>Connective Tissue Grafting/<br>Alloderm Applications |
| <input type="checkbox"/> Apicoectomy                      | <input type="checkbox"/> Treatment Planning for<br>surgical/ implant- restorative<br>options  |
| <input type="checkbox"/> Crown Lengthening                | <input type="checkbox"/> Facial Pain/TMJ Evaluation   |
| <input type="checkbox"/> Ridge Augmentation/Bone Grafting | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Preprosthetic                    |   |
| <input type="checkbox"/> Dentofacial Trauma               |   |

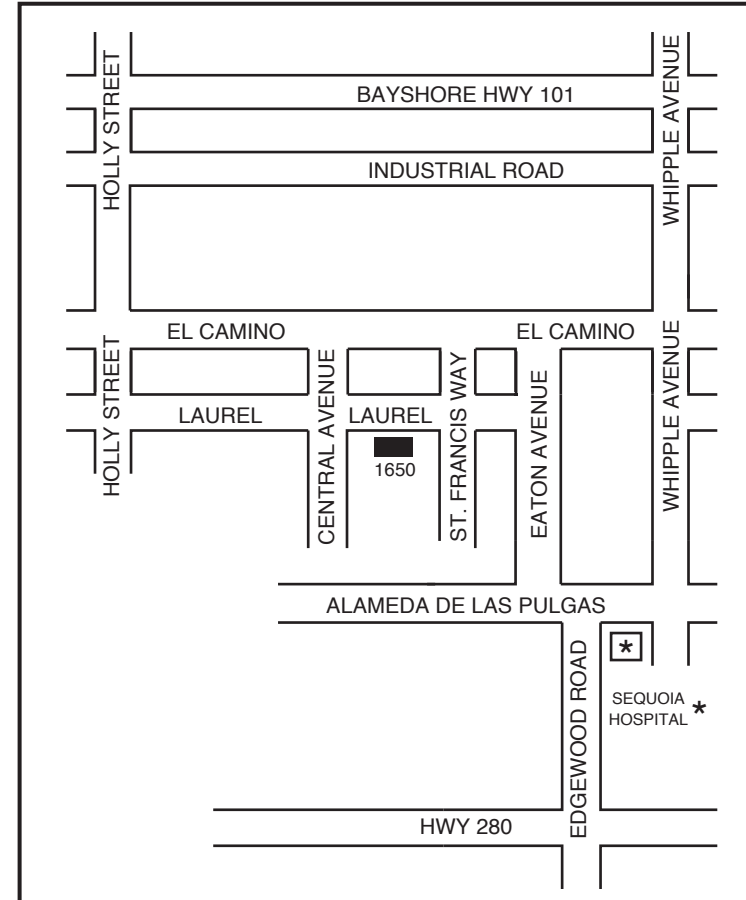
Comments \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_

*John A. Boghossian D.D.S.*

*is located at 1650 Laurel Street, Suite B*

*Between Central Avenue and St. Francis Way*



**PLEASE NOTE MAP IS NOT TO SCALE**