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Today's Date _____

Appointment Information: This time is reserved specifically for you. If by necessity you must cancel your appointment, please notify us at least one day in advance.

Appt. Date _____ Time _____ Day _____

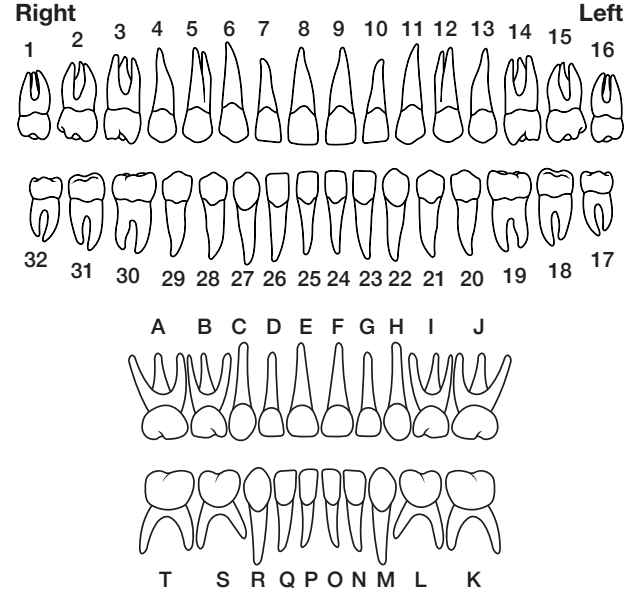
Introducing _____

Patient's Phone _____ X-rays _____

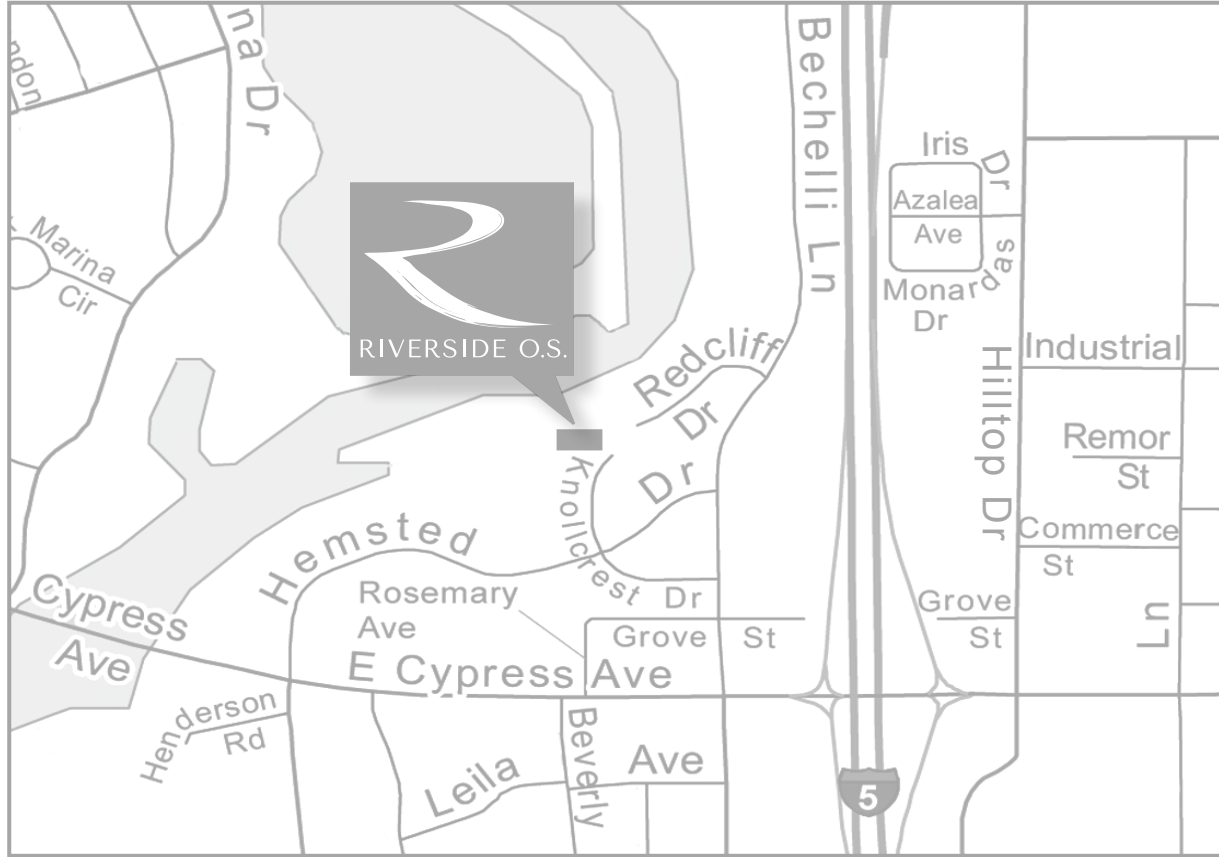
Referred by _____

Comments or Instructions: _____

Please circle the teeth or site(s) to be treated



- | | |
|--|--|
| <input type="checkbox"/> Extraction | <input type="checkbox"/> Surgical Exposure +/- Bonding |
| <input type="checkbox"/> Bone Grafting or Ridge Augmentation | <input type="checkbox"/> Orthognathic Evaluation |
| <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Alveoplasty or Tori Reduction |
| <input type="checkbox"/> Provisional Implant Crown/Bridge | <input type="checkbox"/> Lesion Evaluation |
| <input type="checkbox"/> Full Arch/Mouth Reconstruction | <input type="checkbox"/> Other (please explain) |



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