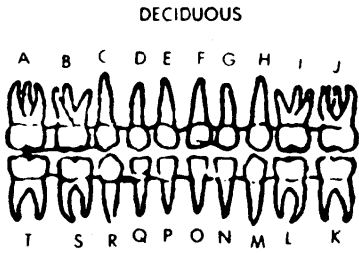
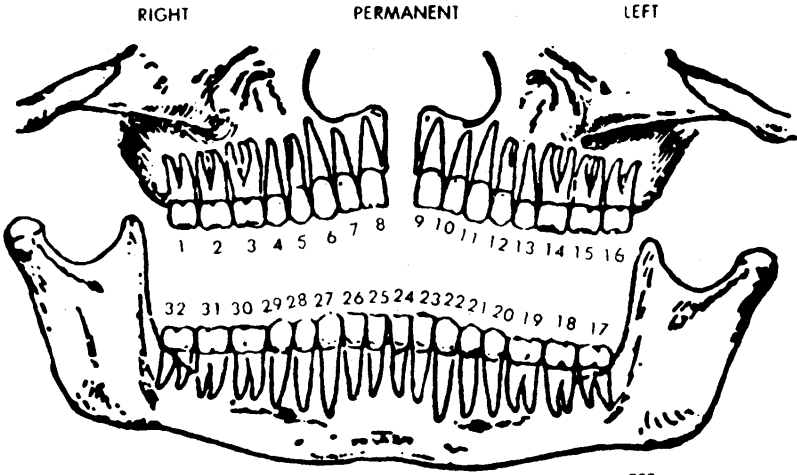


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Patient's Name _____



- | | | |
|---|--|--|
| <input type="checkbox"/> ALVEOLECTOMY | <input type="checkbox"/> CYSTECTOMY | <input type="checkbox"/> TORUS REDUCTION |
| <input type="checkbox"/> BIOPSY | <input type="checkbox"/> MAX & MAND AUGMENTATION | <input type="checkbox"/> TUBEROSITY REDUCTION |
| <input type="checkbox"/> CONSULTATION | <input type="checkbox"/> FRENECTOMY | <input type="checkbox"/> EXPOSURE OF IMPACTED CUSPID |
| <input type="checkbox"/> ORTHOGNATHIC SURGERY | <input type="checkbox"/> EXCISION OF HYPERPLASTIC TISSUE | <input type="checkbox"/> INCISION AND DRAINAGE |
| <input type="checkbox"/> APICOECTOMY | <input type="checkbox"/> DENTAL EXTRACTION | |
| <input type="checkbox"/> ORO-ANTRAL FISTULA CLOSURE | <input type="checkbox"/> DENTAL IMPLANTS | |

REMARKS _____

RADIOGRAPHS ENCLOSED YES _____ NO _____ PLEASE RETURN _____
 REFERRED BY DR. _____ DATE _____