



Craig Mangie, DDS
Oral and Maxillofacial Surgery
Section of Dentistry

Date: _____

Patient Name: _____

Patient DOB _____

Referring Dentist: _____

Date Referred: _____

Patient Phone Number: _____

Dentist Phone Number: _____

- | | |
|---|--|
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Removal of Torus |
| <input type="checkbox"/> Extraction-Routine | <input type="checkbox"/> Frenectomy-Frenoplasty |
| <input type="checkbox"/> Panorex-TMJ xray | <input type="checkbox"/> Incision Drainage |
| <input type="checkbox"/> Impaction | <input type="checkbox"/> Exposure of Unerupted Tooth |
| <input type="checkbox"/> Local Anesthesia | <input type="checkbox"/> Sinus Repair |
| <input type="checkbox"/> Intravenous Anesthesia | <input type="checkbox"/> Dental Implant |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> Enucleation of Cyst |
| <input type="checkbox"/> Alveoplasty | <input type="checkbox"/> Tuberosity Reduction |
| <input type="checkbox"/> Apicoectomy & Root Canal or Retrograde | <input type="checkbox"/> Orthognathic Surgery |
| <input type="checkbox"/> Removal of Hypertrophied Tissue | <input type="checkbox"/> Other |

Comments _____

Please email any current radiographs including recent full mouth series or panoramic films within the past 5 years to dentalimages@ccf.org

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Head and Neck Institute

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