



THIRD COAST

ORAL & MAXILLOFACIAL SURGERY

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Introducing _____ Date _____

Patient Phone _____ DOB _____

Call to appoint Patient will call Appointment made by referring doctor

Referring Doctor _____ Phone _____

PLEASE INDICATE AREA TO BE TREATED

R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
				A	B	C	D	E	F	G	H	I	J				
				T	S	R	Q	P	O	N	M	L	K				
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

PROCEDURES

- | | |
|-------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Third Molars | <input type="checkbox"/> Orthognathic Surgery |
| <input type="checkbox"/> Extractions | <input type="checkbox"/> Oral Pathology |
| <input type="checkbox"/> Dental Implants | <input type="checkbox"/> TMJ Disorders |
| <input type="checkbox"/> Bone Grafting | <input type="checkbox"/> Facial Enhancement Procedures |
| <input type="checkbox"/> Impacted Canines | <input type="checkbox"/> Other: |

X-RAYS

- | | |
|----------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> X-Ray Mailed | <input type="checkbox"/> X-Ray Sent With Patient |
| <input type="checkbox"/> X-Ray Emailed | <input type="checkbox"/> Take X-Ray |

Notes _____

See the reverse for additional information and a map to our office.

Please bring any x-rays or insurance information with you to your appointment.