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Oral Surgery Center of Texoma

Andrew V. Evans, DMD Sara Bahmanyar, DDS, MD Steven F. Kolb, DDS, MSD Todd J. Svane, DDS, MSD

Oral Surgery Evaluation/Treatment Request

Date: _____

Patient: _____

Date of Birth: _____ Phone#: _____

Referring Doctor: _____ Practice Name: _____

Please Evaluate/Treat the Following:

_____

_____

_____

_____

_____

_____

Radiographs:

☐ Emailing (osctfront@outlook.com) **Date of X-ray** _____
☐ Please Take

RIGHT			A	B	C	D	E	F	G	H	I	J			LEFT
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			

Thank you. We look forward to assisting in your patient's care!