

CHRIS STANOSHECK, DDS

HOSPITAL, COSMETIC, & RESTORATIVE DENTISTRY

REFERRING DOCTOR: _____

PATIENT NAME: _____ DATE: _____

SPECIAL NEEDS

RESTORATIVE DENTISTRY

EXTRACTIONS

CONSULTATION

SEDATION/GENERAL ANESTHETIC

EXTENSIVE DECAY

OTHER _____

PLEASE INDICATE TEETH IF APPROPRIATE

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

RADIOGRAPHS TAKEN: YES NO TO BE MAILED PATIENT TO BRING

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