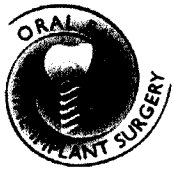

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214-383-1380
fax 214-383-1379
ccokeddsmd@gmail.com

Patient Name: _____ DOB: _____

PLEASE REMOVE THE
PERMANENT
TEETH INDICATED HERE

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
32	**31**	**30**	**29**	**28**	**27**	**26**	**25**	**24**	**23**	**22**	**21**	**20**	**19**	**18**	**17**

PLEASE REMOVE THE
PRIMARY
TEETH INDICATED HERE

A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
E	D	C	B	A	A	B	C	D	E
E	D	C	B	A	A	B	C	D	E
T	**S**	**R**	**Q**	**P**	**O**	**N**	**M**	**L**	**K**

Comments or additional procedures: _____

_____

_____

☐ Patient's x-rays are attached

Referring Doctor Name: _____

Office Phone Number: _____ Date: _____