



# STEELE DENTAL

J. Darrell Steele, DDS, MD  
Oral and Maxillofacial Surgery

Patient Name: \_\_\_\_\_

Referred by: \_\_\_\_\_

Tooth# (s): \_\_\_\_\_

Please:  Evaluate Area: \_\_\_\_\_

Extract

Expose and Bond

Surgically Elevate Tooth

Place Implant

Trim Gingiva

			a	b	c	d	e	f	g	h	i	j			
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			

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referring Doctor Signature \_\_\_\_\_

Date \_\_\_\_\_