IHAB M. HANNA, DDS

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Patient Name_____
Telephone_____Cell_____
D.O.B. _____/_____/_____

Referring Doctor_____
Telephone_____Fax_____
Appt Date_____/_____/_____Time_____

Indicate Area (s):

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

- ❑ ORAL SEDATION OR GENERAL ANAESTHESIA
- ❑ Evaluation and treatment Plan for implant supported prostheses / Sinus lift
- ❑ Extraction of tooth # _____ with immediate / implant placement / Temporization / grafting
- ❑ Fixed Restoration of _____ Maxilla / Mandible Edentulous arch
- ❑ Implant Supported Restoration _____
- ❑ Tension Headache & Trigger Point Injections_____
- ❑ Notes: _____