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Diplomate of the American Board  
of Oral & Maxillofacial Surgery

Date: \_\_\_\_\_ Time \_\_\_\_\_ Day \_\_\_\_\_

Introducing \_\_\_\_\_ Telephone# \_\_\_\_\_

Referred by \_\_\_\_\_ Telephone# \_\_\_\_\_

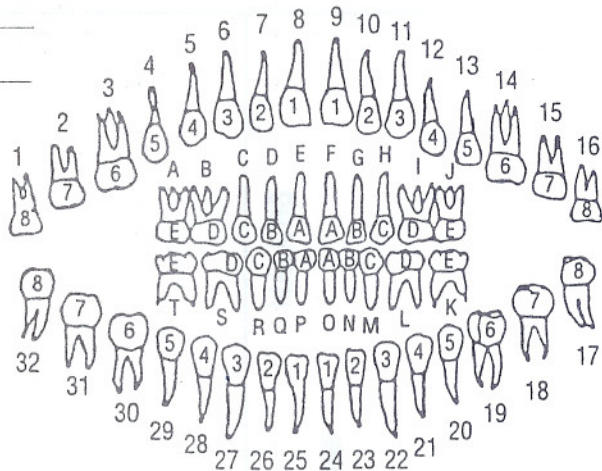
*As Charted Below:*

## RADIOGRAPHS

- |   |   |
|---|---|
| <input type="checkbox"/> Being Mailed     | <input type="checkbox"/> Please Take        |
| <input type="checkbox"/> Given to Patient | <input type="checkbox"/> No X-ray Available |

Please treat as indicated:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Consultation       | <input type="checkbox"/> Alveolectomy          | <input type="checkbox"/> Implant       |
| <input type="checkbox"/> Surgical Removal   | <input type="checkbox"/> Extraction            | <input type="checkbox"/> Cosmetic      |
| <input type="checkbox"/> Impaction          | <input type="checkbox"/> Immediate Restoration | <input type="checkbox"/> Other Surgery |
| <input type="checkbox"/> General Anesthetic | <input type="checkbox"/> Local Anesthetic      |  |



Remarks: \_\_\_\_\_