DocBram

Keith M. Bram, DDS, FICOI, PLLC
Implant Surgery/Prosthetics
1440 Maple Ave., Suite 3A
Lisle, IL 60532
630.963.9280
www.drkeithbram.com

Date: _____

Patient: _____

Address: _____

Send or email X-rays to www.drkeithbram.com

Phone (H): _____ **(W)** _____

❑ Please call pt. ❑ Pt. will call you

Appointment _____ _____ _____

Day **Date** **Time**

Please Circle Teeth to be Treated

Right Left

01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

post space? ❑ Yes ❑ No

Is the patient in pain? none slight moderate severe
Is there swelling? none slight moderate severe
Evaluate for:

periapical surgery
apexification
trauma
luxation / avulsion / fracture

Please call me: ❑ Before examination ❑ After examination
Preferred telephone # _____

Comments:

Dr. _____