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Introducing: _____ Date: _____

Patient Phone: _____ DOB: _____

Referred by Dr: _____ Phone: _____

☐ Comprehensive Exam

☐ Limited Exam

☐ Restorative

☐ Implant

☐ Denture

☐ Extraction

☐ Root Canal Treatment

☐ Periodontal Care

☐ Other: _____

☐ Invisalign

☐ TMJD

☐ Clenching/Grinding

☐ Occlusal Guard

☐ Neurotoxin Injections

☐ Snoring/Sleep Apnea

☐ Oral Sleep Appliance

☐ Imaging

Comments: _____

Date of Most Recent BWX: _____ FMX/Panoramic: _____

Please email most recent radiographs to: info@drhtinnel.com

Date of Most Recent Visit and Treatment Performed: _____

Scan for More Information



Scan to Request an Appointment

