John E. Tillner, DDS
ORAL AND MAXILLOFACIAL SURGERY CENTER
769 Medical Center Ct., Ste 200
Chula Vista, CA 91911

Ph 619-482-6774
Fax 619-482-7637
info@chulavistaoralsurgery.com
www.chulavistaoralsurgery.com

American Board of Oral and Maxillofacial Surgery

COSMETIC, ORAL & MAXILLOFACIAL SURGERY

Patient Name ______________________ Date __________

Referred by Doctor ______________ Referral Phone # __________

Appointment Time ______________ Date __________

Remarks ________________________________

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X-Rays ☐ With Patient ☐ Email
☐ Please Take ☐ Mail

Concerning ☐ Extract ☐ Aesthetics ☐ Sleep Disorder
☐ Implant ☐ TMJ ☐ Orthognathic
☐ Pathology

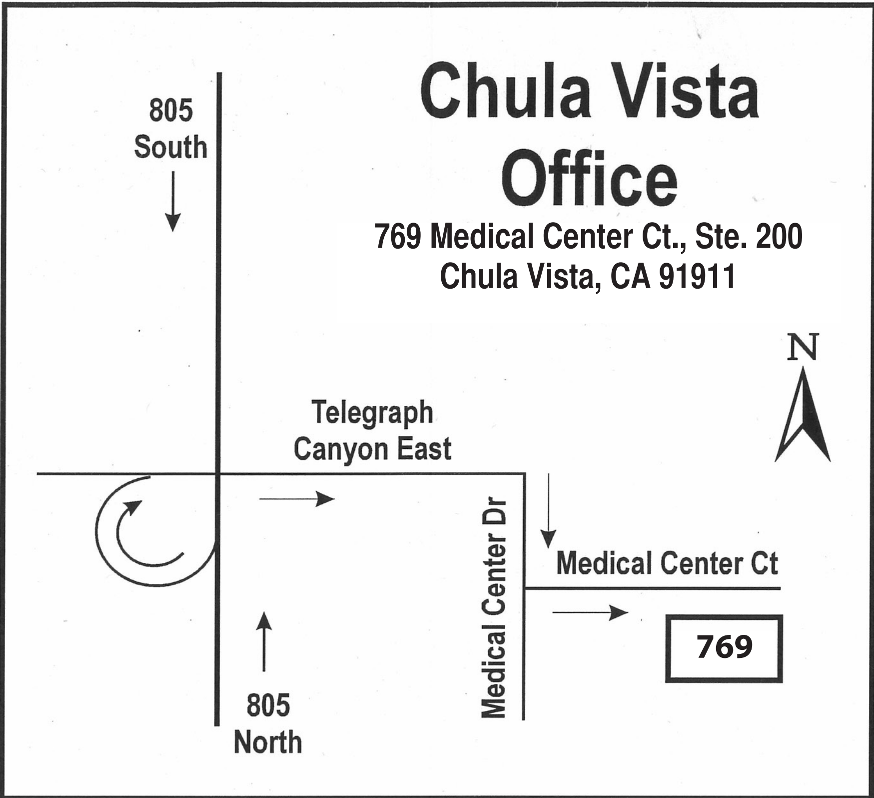
GENERAL ANESTHESIA REQUIRES PRIOR CONSULT*

UPPER

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
R				A	B	C	D	E	F	G	H	I	J				L
				T	S	R	Q	P	O	N	M	L	K				
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

LOWER

**Scan with your Smart Phone for office information*


Chula Vista
Office
769 Medical Center Ct., Ste. 200
Chula Vista, CA 91911
N
805
South
Telegraph
Canyon East
Medical Center Dr
Medical Center Ct
769
805
North