THRIVE
DENTAL & ORTHODONTICS

EXTRACTION/EXPOSE AND BOND REFERRAL

Patient Name: _____ DOB: _____

Date: _____ Office location: _____

☐ Extraction: ☐ Other: _____

☐ Expose/bond:

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

Notes:

_____

_____

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_____

Doctor Name: _____ Date: _____

Doctor Signature: _____ Office location: _____