PATIENT NAME: ______________________

SOCIAL SECURITY NUMBER ___-__-____

IMPLANT SCHEDULE

Diagnostics	DATE
Health History	__/__/__
Blood Studies	__/__/__
Study Models	__/__/__
Pan X-Ray	__/__/__
Other	__/__/__
Medical Evaluation	__/__/__
Dental Evaluation	__/__/__
Template	__/__/__
Consultation	
Surgery	__/__/__
Restorative	__/__/__
Consent Forms	
Request for Treatment	__/__/__
Consent for Bone Graft	__/__/__
Consent for Surgery	__/__/__
Consent for Anesthesia	__/__/__
Consent for Implant Prosthesis	__/__/__

SURGERY

Stage I	DATE
Surgery	__/__/__
Sutures Removed	__/__/__
Check Ups	__/__/__
	__/__/__
	__/__/__
Stage II	
Surgery	__/__/__
Suture Removal	__/__/__
Final Abutments	__/__/__
Suture Removal	__/__/__
Check Ups	__/__/__
	__/__/__
	__/__/__

NOTES:

RESTORATIVE

RESTORATIVE	DATE
Preliminary Impression	__/__/__
Final Impression	__/__/__
Maxillomandibular Relations	__/__/__
Transitional Prosthesis I	__/__/__
Wax Try - In	__/__/__
Transitional Prosthesis II	__/__/__
Delivery	
Permanent teeth -	__/__/__
Initial	__/__/__
Permanent teeth - Final	__/__/__
Bite & Home Care	__/__/__
Check Ups	__/__/__

POST - OP RECOV-

	STAGE I	STAGE II
Post - Op Instructions	____	____
Ice Packs	____	____
Gauze	____	____
Prescriptions	____	____
Record Patient		
Blood Pressure	____	____
Vital Signs	____	____
Review		
Post - Op Instructions	____	____
Patient Record	____	____
Anesthetic Record	____	____

DISCHARGED

The patient was discharged into the care/company of:

Stage I

____
Name of individual discharged to

____
Signature of Medical Staff Member

Stage II

____
Name of individual discharged to

____
Signature of Medical Staff Member