TREATMENT REQUEST
TO CRAIG S. SUTTON, D.D.S. INC

519 W. WHEATLAND RD.
DUNCANVILLE, TEXAS 75116

OFFICE: 972-296-2921 | FAX: 972-296-0277

EMAIL: CSUTTONDDS@GMAIL.COM

Date:_____

Referring Doctor:_____

Patient:_____

Patient Telephone:_____

This patient has been asked to contact your office for:

- ☐ Examination
- ☐ X-Rays:_____
- ☐ Extractions
- ☐ Other services as noted below
- ☐ Surgically uncover_____
- ☐ Gingival Graft
- ☐ Maxillary Frenectomy

Maxillary

E D C B A A C D E

R | 8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8 | L

R | 8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8 | L

E D C B A A C D E

Mandibular

Enclosures

- ☐ Panoramic X-ray for your records
- ☐ Panoramic X-ray, please return

Any questions to the above, please do not hesitate to call

Referring Doctor:_____

Telephone:_____