



# TWIN PINES EXTRACTION AND DENTURE CENTER

Dr. Joseph R. Livingston, DDS

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/Town \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

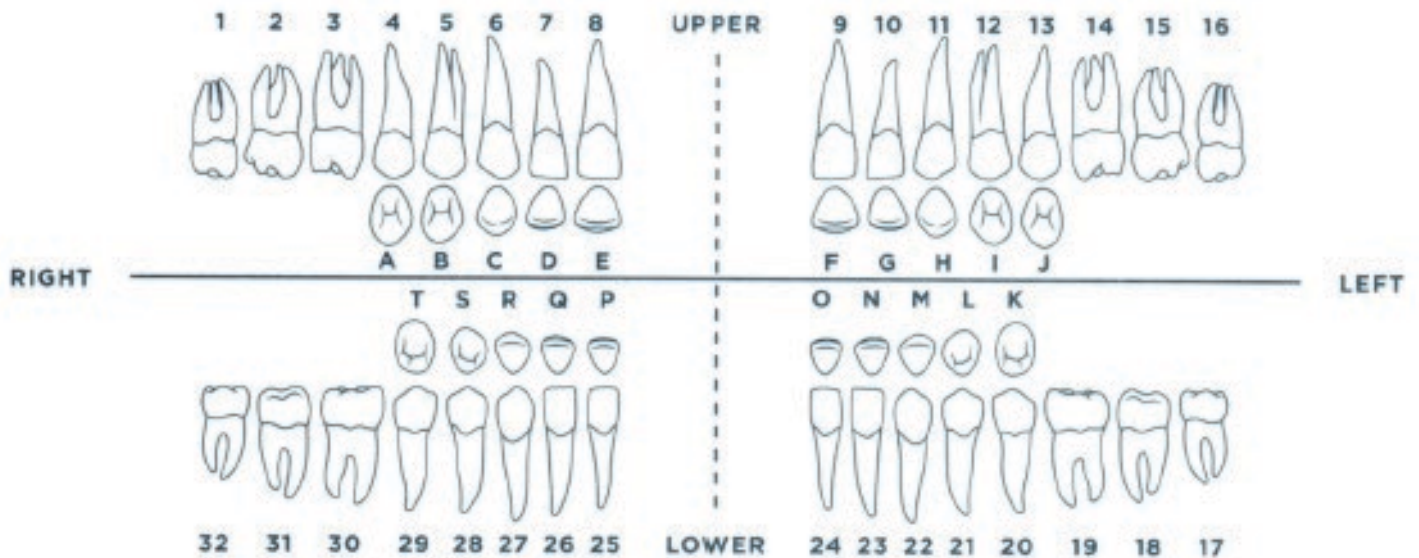
Email \_\_\_\_\_

Dental Insurance: No Yes (If insured, SS#): \_\_\_\_\_

Patient's Insurance Information \_\_\_\_\_

Special Instructions \_\_\_\_\_

- Extraction(s)     
  Dentures     
  Implant(s) for Denture Retention



X-Rays Included?  Yes  No Email to: [extractionsanddentures@gmail.com](mailto:extractionsanddentures@gmail.com)

Referred by Dr. \_\_\_\_\_

Phone \_\_\_\_\_