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Referring: _____

Referred by Dr. _____ Date: _____

Appointment Date/Time: _____

Previous Periodontal Treatment: _____

PLEASE EVALUATE:

Implant Therapy _____

Surgical Guide Provided: ___ Yes ___ No

Would like the patient returned to my office after the following implant stage is complete:

___Healing Screws ___Prosthetic Abutment ___Temporary Crown/Bridge

Periodontal Condition

Cosmetic Crown Lengthening

Gingival Recession/Grafting # ___

Crown Lengthening # ___

Impacted Tooth Exposure # ___

Periodontal Abscess # ___

Frenulectomy & Fiberotomy # ___

Periodontal Maintenance

Special Problem Areas Limited to Tooth/Teeth # _____

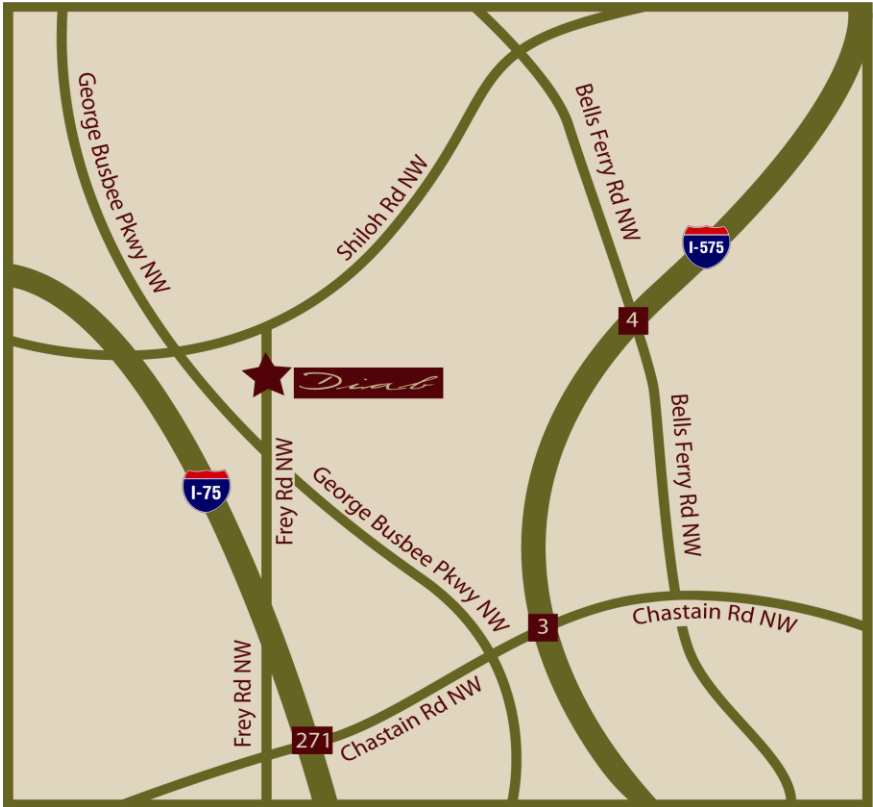
Restorative Treatment Plan _____

Remarks _____

RADIOGRAPHS: Sent with Patient

Mailed

To be taken



We are serious about providing superior service and are proud of our dedication to our patients and their periodontal care.

In order to make your visit go as smoothly as possible, please provide us with the following information at your consultation:

- The referral slip from your referring dentist.
- Any other pertinent information from your referring dentist.
- Any current x-rays.
- Any dental insurance information.
- The Patient Information Form and signed Consent for Services that you will receive in the mail before your appointment. Please complete this form as accurately as possible – all information will be kept in your confidential dental record.

We look forward to meeting you! please feel free to contact us about any questions or concerns about your appointment.

**If you are unable to keep an appointment, please provide at least 48 hours notice so that this time may be dedicated to other patients.