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*Periodontics • Dental Implants • LANAP • Tissue Grafts*

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Introducing _____ Telephone_____

Referred by Dr_____ Date_____

Patient email _____ Mobile Phone_____

Referring patient for:

_____ Complete Periodontal Evaluation

_____ Dental Implants

_____ Extraction and Socket Preservation

_____ Gingival Tissue Regeneration - Root Coverage

_____ Mucosal Tissue Corrections

_____ Laser Therapy, LANAP/LAPIP

_____ Sleep Apnea

_____ Crown Lengthening

_____ Other Services - Pathology

Areas of special concern: _____

Recent Full Mouth Radiographs: ☐ Accompany ☐ Mailed ☐ Emailed

How long has the patient been in your practice?_____ Last examination on

_____ Patient's level of concern_____

What treatment has he/she had in your office to date? _____

☐ Initial examination and full mouth radiographs. Date of this service _____

☐ Prophylaxis and Gross Scaling

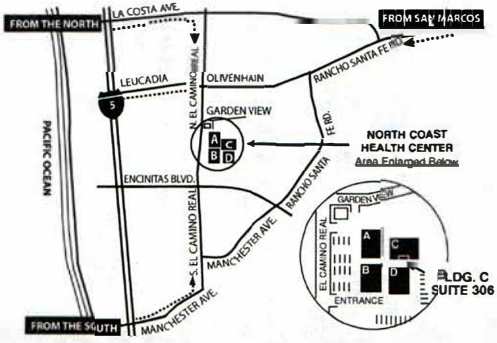
☐ Root Planing. Date(s) of service _____ ___ Quadrants: _____

☐ Periodontal Maintenance Therapy every _____months for _____years.

☐ Extensive Restorative Therapy

☐ Other _____

Tentative Restorative Plans _____




APPOINTMENT DATE: _____ TIME:_____