PERIODONTICS & IMPLANT CENTER

Date: _____ Patient Name: _____

Referred By:_____ Referral Phone: _____

Patient Phone: _____ ○ (h) ◉ (c) ○ (w)

Patient Address: _____

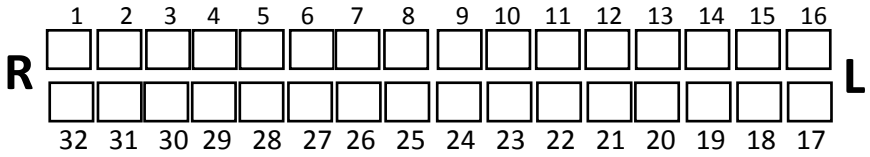
Medical Alerts: _____

Planned Restorative Tx: _____

Services Needed:

☐ Periodontal Disease	☐ Dental Implants	☐ Gingival Grafting
☐ LANAP	☐ Extraction	☐ Crown Lengthening
☐ Sedation: IV/N20/Oral	☐ Sinus Lift/Ridge Augmentation	☐ Oral Pathology / Biopsy
☐ TADs	☐ Perio-Implant Disease	☐ Circumferential Fibrotomy
☐ HPV/DNA/Bacterial Testing	☐ Orthodontic Tx: Exposure / Frenectomy	☐ Call Our Office Prior to Examining Patient

Teeth to be Evaluated / Treated:



Radiographs: ☐ Please Take ☐ Being Sent Date of Radiographs: _____

Referred to Doctor: 1st Available ☐ Dorion ☐ Gandini ☐ Kadoma ☐ Walters ☐ Wu ☐

Comments:

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