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Introducing: _____ ☐ Premed Request

Home: _____ Work: _____ Mobile: _____

☐ Patient will call ☐ Please call patient for appointment

Referring doctor(s): _____ Date: _____

Ref Doc Address: _____ Ref Doc Tel: _____

Ref Doc Email: _____ Ref Doc Fax: _____

☐ Comprehensive examination (multiple sites) ☐ Limited Exam

☐ Gingival recession ☐ Perio Disease

☐ Implants ☐ Crown lengthening ☐ Esthetic concerns

Areas of Concern:

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15	☐ 16
32 ☐	31 ☐	30 ☐	29 ☐	28 ☐	27 ☐	26 ☐	25 ☐	24 ☐	23 ☐	22 ☐	21 ☐	20 ☐	19 ☐	18 ☐	17 ☐

Preferred Implant System: _____

Anticipated Restorative Treatment Plan following completion of Periodontal Therapy:

_____

_____

Additional Information:

_____

_____

Past Root Planing date: _____ Past Maintenance Frequency: _____

Radiographs:

☐ Radiographs enclosed ☐ Radiographs will be emailed ☐ Take new radiographs

☐ FMX w/Bitewings ☐ Bitewings ☐ Periapical(s) ☐ PAN ☐ CT Scan