PATIENT INFORMATION:
Today’s Date: __________ DOB: __________
First Name: ____________________________
Last Name: ____________________________
Home Phone: ____________________________
Office Phone: ____________________________
Cell Phone: ____________________________

PLEASE CONTACT ME:
☐ After examination by phone
☐ After examination by email
☐ After examination by mail

REASON FOR REFERRAL:
☐ Periodontal Disease
☐ Dental Implants
☐ Ridge/ Sinus Augmentation
☐ Extraction/ Socket Preservation
☐ Recession/ Mucogingival defect
☐ Crown Lengthening
☐ Gingival Contouring for Cosmetics
☐ Wilckodontics
☐ Other ____________________________

REFERRING DOCTOR INFORMATION:
Referred By: ____________________________
Phone: ____________________________
Email: ____________________________

PLEASE INDICATE TOOTH/ AREA TO BE EVALUATED:

IMPLANT SYSTEM: ☐3i ☐ Biohorizon ☐ Zimmer
☐ Nobel Biocare ☐ Other ____________________________

RADIOGRAPHS:
☐ Given to patient ☐ Being mailed
☐ Please take ☐ Being emailed

SURGICAL TEMPLATE:
☐ Provided by restorative dentist ☐ Provided by periodontist

PERIODONTAL HISTORY:
☐ Scaling and root planning. Date: __________
☐ Other: ____________________________

RESTORATIVE PLANS:
☐ Teeth planned for extraction __________
☐ Other: ____________________________

REMARKS OR SPEICAL INSTRUCTIONS:

______________________________

______________________________