Dental Implant & Periodontal Specialists

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PATIENT INFORMATION

Last Name	First Name	Date of Birth	Referral Date

Home Phone	Cell Phone	
		_____Patient will call for appointment

Does the patient require antibiotics prior to treatment? _____ Yes _____ No

Pertinent Medical History/Alert:

REFERRING DOCTOR INFORMATION

Referring Doctor:

Phone #: Email:

Please send report via: _____ Mail _____ Email _____ Fax

REASON FOR REFERRAL

_____ Implants Preferred Implant System _____

_____ Periodontal Evaluation _____ Exposure Impacted Tooth _____ Ridge Augmentation

_____ Esthetic Crown Lengthening _____ Periodontal Regeneration _____ Gingival Recession

_____ Pre-Prosth Crown Lengthening _____ Other (Explain below)

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

PERIODONTAL TREATMENT COMPLETE IN REFERRING/OTHER OFFICE

_____ Prophylaxis/Gross Scaling _____ Root Planing _____ Maintenance Therapy _____ Surgical tx

POSSIBLE EXTRACTIONS

Yes _____ No _____ If Yes, tooth number(s): _____

RADIOGRAPHS/CLINICAL PHOTOS

Date of Most Recent Radiographs: _____

_____ Mailed

_____ Emailed

_____ Given to Patient

Please Take:

_____ FMS

_____ Digital Pan

_____ CBCT

RESTORATIVE TREATMENT PLAN/ADDITIONAL INFORMATION