



# MILTON GEIVELIS, D.D.S., M.S.

PRACTICE LIMITED TO PERIODONTICS

DIPLOMATE, AMERICAN BOARD OF PERIODONTOLOGY

106 W. Bartlett Ave.

Bartlett, Illinois 60103

PH: (630) 830-4930 Fax: (630) 830-4953

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

Referring Health Professional: \_\_\_\_\_

Appointment on: \_\_\_\_\_ Time: \_\_\_\_\_

### The Area of Major Concern:

(Please circle all that apply)

**Breastfeeding:** (Tongue-Tie, Lip-Tie upper, Lip-Tie Lower, Buccal-Tie upper, Buccal-Tie Lower)

**Speech Problems:** (Tongue-Tie, Lip-Tie upper, Lip-Tie Lower, Buccal-Tie upper, Buccal-Tie Lower)

**Sleep Apnea**

**Other Information:** (Gum Recession, Tooth Spacing)

**Please forward documents and photos to our secure e-mail: [info@drmiltongeivelis.net](mailto:info@drmiltongeivelis.net)**

This Patient is:  New to my Practice  # of years in Recall \_\_\_\_\_

I would like Dr. Geivelis to call \_\_\_\_\_  before or  after examination

I would like Dr. Geivelis to write \_\_\_\_\_  report after exam  report after treatment

