Dental Implant & Periodontal Specialists

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PATIENT INFORMATION

Last Name	First Name	Date of Birth	Referral Date
Home Phone	Cell Phone	Patient Email	

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 COMPLETED IN REFERRING/OTHER OFFICE

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

POSSIBLE EXTRACTIONS

Yes ______ No ______ If Yes, tooth number(s): ____________________

PLEASE SEND MOST RECENT RADIOGRAPHS/PHOTOS

Date of Most Recent Radiographs: ____________________

______ Mailed

______ Emailed

______ Given to Patient

Please Take:

______ FMS

______ Digital Pan

______ CBCT

RESTORATIVE TREATMENT PLAN/ADDITIONAL INFORMATION