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• Advanced Implant & Dentoalveolar Surgery • Periodontal Plastic Surgery • Comprehensive Periodontal Medicine

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Patient's Name _____ Referring Dr. _____ Phone _____ Date _____ Pre-Medication Required? Yes No

If yes, please take 1 hour prior to exam

Last Treatment in your office was for _____

Have you advised the patient of the possibility of extraction of any teeth?
 Yes No If so, which teeth? _____

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

REASON FOR REFERRAL

- | | | | | | |
|--|---|--|---|---|---|
| <input type="checkbox"/> PERIODONTAL EVALUATION | Specific issues and procedures : | | | | |
| <input type="checkbox"/> DENTAL IMPLANT CONSULTATION | <input type="checkbox"/> Pockets | <input type="checkbox"/> Recession | <input type="checkbox"/> Ridge Augmentation | <input type="checkbox"/> Surgically Assisted Ortho | <input type="checkbox"/> Incision & Drainage |
| <input type="checkbox"/> COSMETIC CONSIDERATIONS | <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Thin/Fragile gingiva | <input type="checkbox"/> Soft Tissue Augmentation | <input type="checkbox"/> Crown Lengthening | <input type="checkbox"/> Gingival Plastic Surgery |
| <input type="checkbox"/> SMILE ENHANCEMENT | <input type="checkbox"/> Mobility | <input type="checkbox"/> Shallow Vestibules | <input type="checkbox"/> Sinus Augmentation | <input type="checkbox"/> LANAP/LAPIP | <input type="checkbox"/> Alveoloplasty |
| <input type="checkbox"/> ORTHO-PERIO COMPLICATIONS | <input type="checkbox"/> Inflammation | <input type="checkbox"/> Lack of Keratinization | <input type="checkbox"/> Site Prep/ GBR | <input type="checkbox"/> Frenectomy/ Vestibuloplasty | <input type="checkbox"/> Cavitation Surgery |
| <input type="checkbox"/> ENDO-PERIO COMPLICATIONS | <input type="checkbox"/> Furcation | <input type="checkbox"/> Frenum Pull | <input type="checkbox"/> Impacted Canine Exposure | <input type="checkbox"/> Distal/Mesial Wedge | <input type="checkbox"/> Extraction _____ |
| <input type="checkbox"/> CAVITATION TREATMENT | <input type="checkbox"/> Peri-Implantitis | <input type="checkbox"/> Partial/Full Edentulism | <input type="checkbox"/> Periodontal Regeneration | <input type="checkbox"/> Full Mouth Implant Tx Design | <input type="checkbox"/> Implant _____ |
| | <input type="checkbox"/> Other _____ | | | | |

Special concerns/ comments : _____

Do you have any restorative plans for treating this case? Yes No If yes, please briefly outline your plans : _____

Last full-mouth radiographs Given to Patient Emailed to your office
 Date taken _____ Please Take New Mailed to your office

Scaling and root planing completed Yes No
 Date performed _____