IMPLANT & PERIODONTIC SPECIALISTS

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Date:_____

Patient:_____ Patient Phone:_____

Referring Doctor (s):_____

Would you like us to call your patient to setup an exam? ❑ Yes ❑ No
Does patient need premedication? ❑ Yes ❑ No
Is this an EMERGENCY Exam? ❑ Yes ❑ No

COMPREHENSIVE EXAMINATION FOR

_____ Scaling and Rootplaning/Perioscope
_____ Complete Perio/Generalized Boneloss
_____ Recession/Root Coverage
_____ Frenectomy/Fiberotomy
_____ Peri-Implantitis
_____ PAOO
_____ Dental Implants
_____ Extraction/Root Amputation
_____ IV Sedation
_____ Clinical Crown Lengthening/Cosmetic Crown Lengthening
_____ Ortho Involved (Pre-Ortho, TAD, PAOO)
_____ Canine Exposure
_____ Ridge/Sinus Augmentation
_____ Implant Brand/Type Request
_____ Wisdom Teeth
_____ Biopsy/Velscope

ALL RADIOGRAPHIC HISTORY

FMX (_____/_____/_____) *Date
PANO (_____/_____/_____) *Date
BWS (_____/_____/_____) *Date
PA (_____/_____/_____) *Date

NONE, we take for concerns ❑ Yes

DOES PATIENT HAVE PERIO HISTORY ❑ Yes ❑ No

Date of Scaling & Root Planning (_____/_____/_____)

REFERRING DDS COMMENTS:

_____

_____

_____

Restorative Plans being pursued: _____

Orthodontia Plans being pursued: _____