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Specialist in Periodontics & Dental Implants
Diplomate of the American Board of Periodontology

PATIENT'S NAME		
PATIENT'S TELEPHONE: WORK:	HOME:	
PATIENT TO B	E SEEN FOR:	
<ul> <li>□ Complete Periodontal Exam &amp; Therapy</li> <li>□ Aesthetic Periodontal Therapy (please call for "aesthete")</li> <li>□ Pathology</li> </ul>	☐ Limited Exam & ☐ Implant Therapy ☐ Other	
DIAGNOSTIC	MATERIALS:	
Is a full mouth series or of affected area enclosed?	☐ Yes ☐ No If Yes, does it have to be returned If No, would you like a copy?	rned?
Are diagnostic models enclosed? (if needed)	☐ Yes☐ No If Yes, do they have to be returned If No, would you like a copy of	irned? f the set?
Would you like us to make the stents for:		
PERIODONTAL TR	REATMENT COMPLETED:	
<ul> <li>□ Plaque Control and Oral Hygiene Instruction (da</li> <li>□ Root Planing and Scaling (quads</li> </ul>		
FIITURE	RESTORATIVE	
□ Crowns on #'s □ Bridges on #'s □ Remov. prosth. (location) □ Caries on #'s		
☐ Carles on #'s ☐ Old Alloy Amalgam Replacement on #'s ☐ Cosmetics/Veneers/Composites on #'s ☐ Other		
I would appreciate your discussing these restor	rative needs with the natient  Yes	No
CASE PL	ANNING	
☐ Letter ☐ Please call BEFORE examina	ation Please call AFTER examin	nation
RIGHT A B C D E		nation
RIGHT A B C D E	F G H I J LEFT 9 10 11 12 13 14 15 16	nation
RIGHT A B C D E 1 2 3 4 5 6 7 8 32 31 30 29 28 27 26 25	F G H I J LEFT 9 10 11 12 13 14 15 16 24 23 22 21 20 19 18 17	nation
RIGHT A B C D E	F G H I J LEFT 9 10 11 12 13 14 15 16 24 23 22 21 20 19 18 17 O N M L K	nation
RIGHT A B C D E 1 2 3 4 5 6 7 8 32 31 30 29 28 27 26 25 T S R P Q	F G H I J LEFT 9 10 11 12 13 14 15 16 24 23 22 21 20 19 18 17 O N M L K	nation
RIGHT A B C D E  1 2 3 4 5 6 7 8  32 31 30 29 28 27 26 25  T S R P Q  COMM  Dr. Name	F G H I J LEFT 9 10 11 12 13 14 15 16 24 23 22 21 20 19 18 17 O N M L K	

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