



Periodontics & Implants

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Patient Name: _____

Referring Doctor: _____

Patient Phone: _____

Doctor Phone: _____

Today's Date: _____

Doctor Email: _____

Areas of Concern/Desired Treatment:

☐ Periodontal Pocketing/Bone Loss _____

☐ Extraction(s) _____

☐ Gingival Recession/Tissue Graft _____

☐ Bone Grafting _____

☐ Laser Frenectomy _____

☐ Dental Implant(s) _____

☐ Gummy Smile Reduction _____

☐ TeethXpress® _____

☐ Crown Lengthening _____

☐ Alveoloplasty _____

☐ Gingival Contouring _____

☐ Sinus Lift/Ridge Augmentation _____

☐ Biopsy _____

☐ Other/Restorative/Comments _____

☐ Orthodontic Exposure/Bracket _____

Radiographs:

☐ PAX *Date Taken:* _____ ☐ FMX *Date Taken:* _____ ☐ 3D/CT Scan *Date Taken:* _____

☐ BWX *Date Taken:* _____ ☐ Pano *Date Taken:* _____ ☐ Please Take Necessary Radiographs



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