Date: _____

Introducing: _____

Time and Date of Appointment: _____

FOR PROCEDURE AS FOLLOWS:

- ☐ Dental Implant Evaluation
- ☐ Comprehensive Full Mouth Examination
- ☐ Isolated Areas _____
- ☐ Emergency Treatment _____

PERIODONTAL HISTORY:

Patient Compliance ☐ Regular ☐ Sporadic

Recall Schedule Every _____ Months

PREVIOUS PERIODONTAL THERAPY:

- ☐ None
- ☐ Maintenance Only
- ☐ Scaling/Root Planing
- ☐ ☐ UR ☐ UL ☐ LL ☐ LR Date Completed _____
- ☐ Periodontal Surgery
- ☐ ☐ UR ☐ UL ☐ LL ☐ LR Date Completed _____
- ☐ Other _____

RADIOGRAPHS:

- ☐ Complete Series to be *emailed* prior to appointment
- ☐ Complete Series to be sent prior to appointment
- ☐ Current radiographs are not available, please take any x-rays you feel are necessary for your diagnosis and treatment

PLEASE CONTACT ME PRIOR TO BEGINNING TREATMENT:

- ☐ Prior to Consultation
- ☐ Telephone ☐ E-Mail

SPECIFIC RESTORATIVE PLANS:

- ☐ I am planning the following restorative (or other) treatment

  _____

- ☐ Please make recommendations/suggestions which you feel are appropriate

UPON COMPLETION OF ACTIVE PERIODONTAL THERAPY, I WOULD PREFER TO:

- ☐ Ask you to do all necessary scaling for periodontal maintenance
- ☐ Alternate periodontal maintenance with you
- ☐ Do all periodontal maintenance myself
- ☐ Other _____

SPECIAL INSTRUCTIONS:

- ☐ Medical Complications
- ☐ Premed
- ☐ Other _____

Dr. _____

Telephone _____ E-Mail _____

Address _____

ENCLOSED

- ☐ Radiographs
- ☐ Pocket Markings
- ☐ Other _____