CAPITAL PERIODONTAL

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Today's Date_____Referred by Dr. _____

Patient Name_____Date of Birth_____

Patient Phone_____Patient Email_____

REASON FOR REFERRAL

PRE-PROSTHETIC TREATMENTS

❑ Extraction(s) with Ridge Augmentation ❑ Ridge Reduction/Tori Removal

DENTAL IMPLANTS

❑ Single/Multiple ❑ Full Arch Replacement

SOFT & HARD TISSUE REGENERATION

❑ Gingival Recession ❑ Bone Grafting/Sinus Lift

AESTHETIC & RESTORATIVE PERIODONTAL THERAPY

❑ Crown Lengthening ❑ Treatment of Gingival Enlargement/Hyperplasia

PERIODONTAL & PERI-IMPLANT DISEASE THERAPY

❑ Pocket Reduction Therapy ❑ Periodontal Scaling & Root Planing

ORTHODONTIC ADJUNCTIVE PROCEDURES

❑ Frenectomy/Fiberotomy ❑ Tooth Exposure

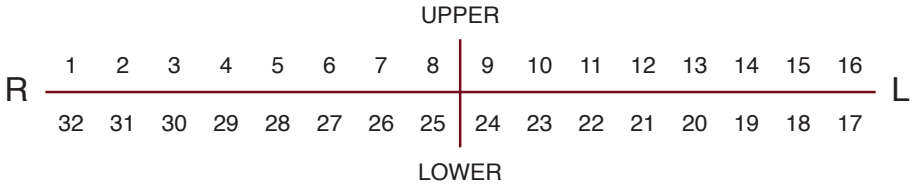
ORAL PATHOLOGY

❑ Oral Biopsy ❑ Diagnosis & Management of Oral Lesions ❑ Tooth Exposure

EMERGENCY

❑ Other: _____

AREA OF CONCERN



RADIOGRAPHS

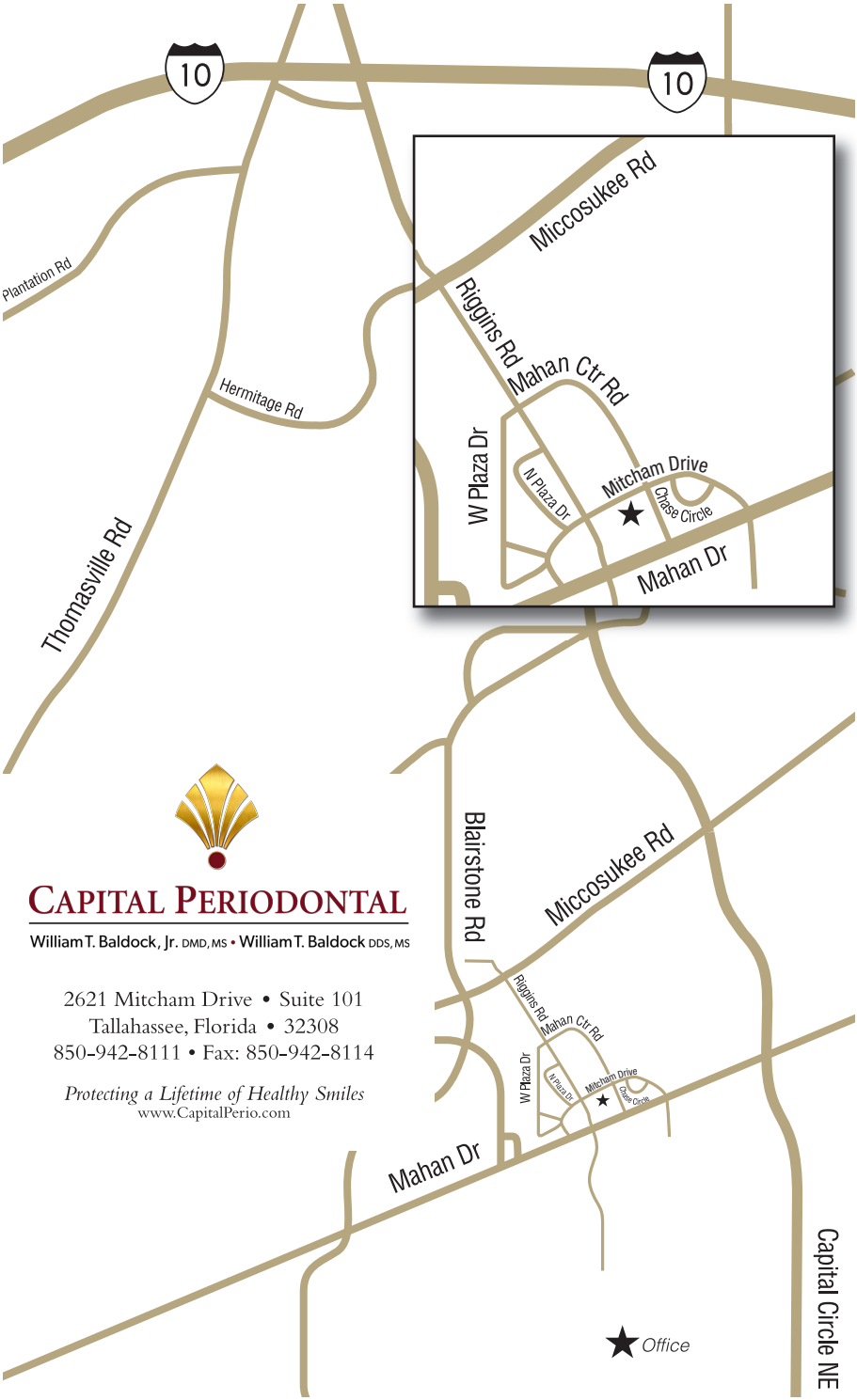
❑ Sending X-rays for teeth #(s)_____

Please take the following radiographs

❑ X-rays ❑ 3D Cone Beam Scan

ADDITIONAL COMMENTS: _____

_____



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Protecting a Lifetime of Healthy Smiles
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