



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

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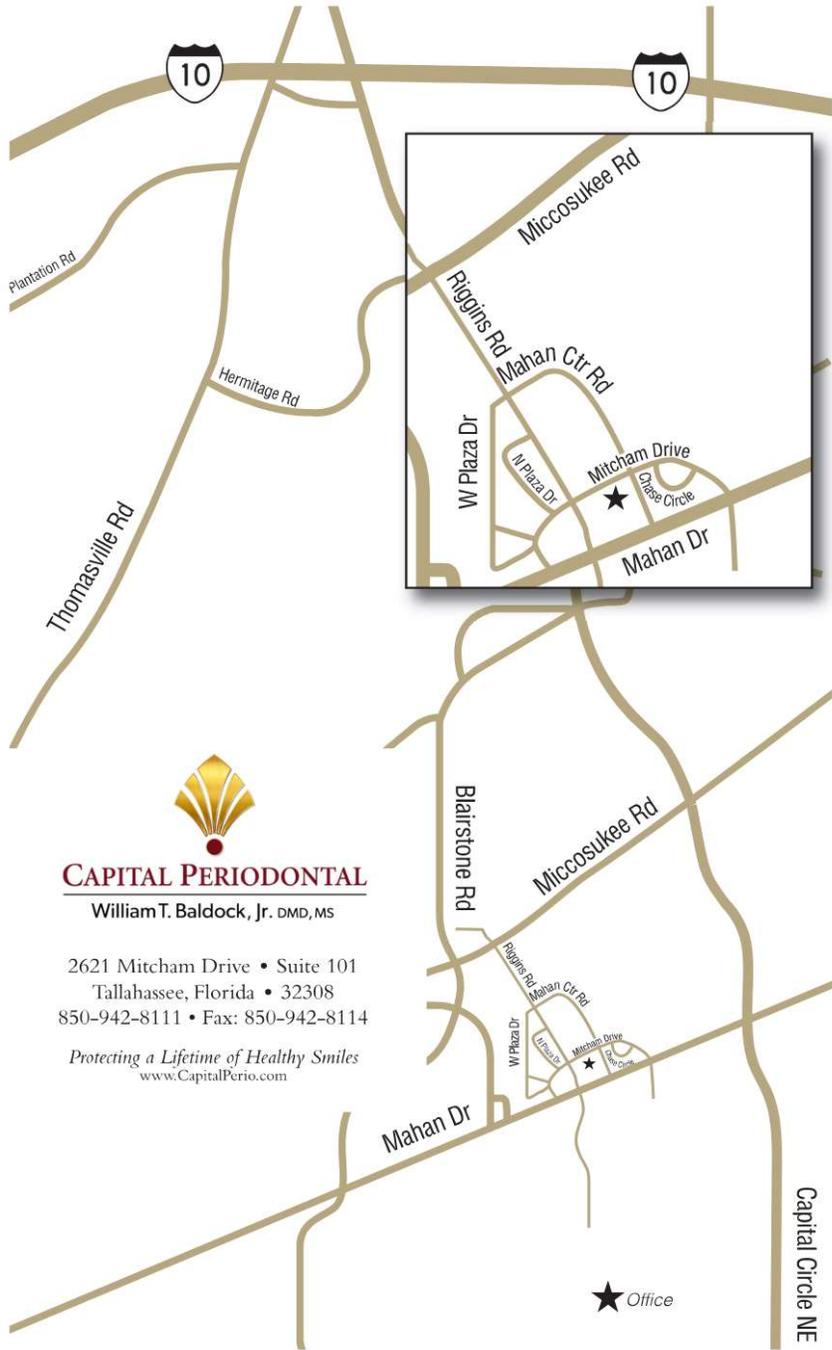
RADIOGRAPHS

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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★ Office