

From Dr. \_\_\_\_\_

Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Patient's Contact number: \_\_\_\_\_

Tooth to be Evaluated	R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

**Referred For**

- |   |  |
|---|--|
| <input type="checkbox"/> Complete Periodontal Exam                | <input type="checkbox"/> Implant                       |
| <input type="checkbox"/> Periodontal Regeneration/ Bone Grafting  | <input type="checkbox"/> All-On-Four                   |
| <input type="checkbox"/> Gingival Recession / Mucogingival Defect | <input type="checkbox"/> Sinus Lift                    |
| <input type="checkbox"/> Frenectomy                               | <input type="checkbox"/> Extraction, Site Preservation |
| <input type="checkbox"/> Crown Lengthening                        | <input type="checkbox"/> Wisdom Teeth Extraction       |
| <input type="checkbox"/> Biopsy                                   | <input type="checkbox"/> Exposure of impacted tooth    |

**Preferred Implant System**  
 \_\_\_\_\_

**Preferred Hygiene/Periodontal Maintenance at**  
 Periodontist    Alternating    Referring Dentist

**Preferred Scaling & Root Planing at**  
 Periodontist    Referring Dentist

Additional information: \_\_\_\_\_



Scan to schedule an appointment