EPIC PERIODONTICS & IMPLANT CENTER

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www.epicperiodontics.com

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
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

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Referred For

- ☐ Complete Periodontal Exam
- ☐ Periodontal Regeneration/ Bone Grafting
- ☐ Gingival Recession / Mucogingival Defect
- ☐ Frenectomy
- ☐ Crown Lengthening
- ☐ Biopsy
- ☐ Implant
- ☐ All-On-Four
- ☐ Sinus Lift
- ☐ Extraction, Site Preservation
- ☐ Wisdom Teeth Extraction
- ☐ 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