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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 _____