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Periodontics • Implant Dentistry
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DATE _____
PATIENT NAME _____
PATIENT'S ADDRESS _____
_____
TELEPHONE _____
_____

REFERRED BY DR. _____

Patient is new to my practice Patient of record, _____ years
FOR:

Periodontal Evaluation
1. How long has he/she been a patient? _____
2. When did you first recommend he/she see a periodontist? _____
3. Has a scaling been done at GP's office in the last 6 months? ☐ Yes ☐ No
4. Have you used code #4341 or #4342 within the last 2 years? ☐ Yes ☐ No
5. What recall cycle has the patient been on? _____
6. Date of last recall __/__/__

Crown Lengthening Tooth # (s) _____
Soft Tissue Graft Tooth # (s) _____
Dental Implants Tooth # (s) _____
Ridge / Sinus Augmentation Tooth # (s) _____
Removal and Bone Graft Tooth # (s) _____
IV Sedation / Nitrous Oxide
Other _____

DIAGNOSTIC FILMS
A complete series will be: sent with patient mailed required
emailed to films@MiamiPerio.com

RESTORATIVE TREATMENT PLAN

_____
_____