

Referring doctor:

Patient: _____

Appointment date: _____

Radiographs: Please take new radiographs

Time:

5525 S. Staples St. • The Enclave, Suite A4 Corpus Christi, TX 78411 Phone: 361-992-7641 Fax: 361-992-3337

Implant brand:

• .		LATICULOIT (#).
	☐ Please take a CBCT scan	☐ Laser treatment:
	☐ Accompanying patient	Hygiene / Periodontal Maintenance:
	☐ Mailed to your office	☐ Periodontist ☐ Alternating ☐ Referring denti-
	☐ Emailed to your office	Scaling and Root Planing:
Sedation:		☐ Date completed:
Restorative Needs / Options		☐ Periodontist
		Cosmetic Concerns
		☐ Esthetic crown lengthening:
Paris Arthur Strawers	STREET, STANKE, THE STREET, STANKE, ST	☐ Gingival augmentation:
Comments:		☐ Frenectomy:
		Dental Implants
		Extraction (#):
		☐ Bone graft:
		☐ Sinus lift:
		Implant (#):