Patient's Name:..... Date:.....

(Please ask patient to bring this form to their consultation)

Referred by Dr. .....

Please Provide:

☐ Comprehensive Exam For:

☐ Limited Exam For:

☐ Treat As Needed For:

☐ Bone Graft

☐ Crown Lengthening

☐ Emergency/Abscess

☐ Exposure of Impacted Tooth

☐ Extraction

☐ Frenectomy: UR UA UL / LR LA LL

☐ Implant

☐ Lip Lowering Procedure

☐ Periodontal Pocket/s

☐ Ridge Augmentation

☐ Sinus Lift

☐ Soft Tissue Graft

☐ Other: .....

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

☐ Please Take X-rays As Needed

☐ Sending X-rays For Teeth #(s):.....

Past Root Planning: ☐YES ☐NO Quads: UR LR UL UR

Date Completed: .....

Comments: .....

.....

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