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Diplomates of the American Board of Periodontology

Name: _____ Date: _____

Please call patient to schedule Y N Phone: _____

Appointment Date: _____

X-Ray Available: _____

Referring Doctor: _____ Phone: _____

PERIODONTAL THERAPY

- | | |
|--|--|
| ☐ Complete Periodontal Exam & Treatment | ☐ Soft Tissue Grafting |
| ☐ Limited Exam & Treatment (Teeth # _____) | ☐ Periodontal Bone Grafting |
| ☐ Crown Lengthening (Teeth # _____) | ☐ Other: _____ |
| ☐ Minimally Invasive Laser Periodontal Therapy (via LANAP™) | |

IMPLANT DENTISTRY

- | | |
|---|---|
| ☐ Dental Implants (Sites: _____) | ☐ Ridge Augmentation |
| ☐ Sinus Grafting/Augmentation | ☐ Other: _____ |

ORTHODONTIC SERVICES

- | | |
|--|--|
| ☐ Pre-Orthodontic Gingival Grafting | ☐ Cuspid Exposure |
| ☐ Accelerated Osteogenic Orthodontics | ☐ Forced Eruption |
| ☐ Uneven Gingival Margins | ☐ Gingival Overgrowth |

OTHER SERVICES

- | | |
|--|--|
| ☐ Extractions (Teeth #'s _____) | ☐ IV or Oral Sedation |
| ☐ Pre-Prosthetic (Tori Removal/Alveoloplasty) | ☐ Other: _____ |

Special Instructions or Comments: _____

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