DENTAL SPECIALTIES
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Northwest

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PERIODONTICS/IMPLANTS

Date: _____

Patient: _____

Patient Phone: _____ **Patient Email**: _____

Referring Doctor(s): _____

Does patient need premedication? Yes ___ No ___

Is this an EMERGENCY Exam? Yes ___ No ___

EXAMINATION FOR

___ Complete Perio/Generalized Bone Loss
___ Scaling and Root Planing/Periscope
___ Gum Grafting
___ Crown Lengthening
___ Extraction/Root Amputation
___ Frenectomy/Fiberotomy
___ Laser Treatment (Perio/Cold Sores)
___ All on Four Reconstruction
___ Gummy Smile/Lip Repositioning

___ Dental Implants
___ Peri-Implantitis
___ Ridge/Sinus Augmentation
___ Wisdom Teeth
___ Ortho Involved (TAD, PAOO)
___ Canine Exposure
___ IV Sedation
___ Biopsy/Velscope
___ Alveoplasty/Tori Removal

DOES PATIENT HAVE PERIO HISTORY Yes ___ No ___

Date of Scaling & Root Planing: _____

REFERRING DDS COMMENTS:

_____

_____

_____

_____

We will send X-rays to **info@dentalspecialtiesnorthwest.com**