

Kent M. Hamilton, D.D. S., Inc.
PRACTICE LIMITED TO PERIODONTICS
14500 San Pedro #200 San Antonio, TX 78232
Ph# (210) 496-5603 or (800) 442-5603
Fax #: (210) 496-1286
FAX COVER SHEET NOT REQUIRED
GENERAL DENTAL TREATMENT PLAN

Date: _____ Referring D.D.S.: _____
Patient Name: _____ DOB: _____ SS#: _____
Address: _____ City/State/Zip: _____
Home#: _____ Work#: _____ Cell#: _____ E-mail: _____
Insured's Name: _____ DOB: _____ SS#: _____
Insurance Name: _____ Phone#: _____ Employer Name: _____

REASON FOR REFERRAL: **Implant** **Periodontal**

Periodontitis (Slight, Moderate, Severe) Isolated Procedure # _____
 Recession # _____ Implant # _____
 Impressions Taken _____ Consultation _____

I AM SENDING: **Treatment Plan** **Probe Chart** **FMX** **Date Taken** _____

BWX PAX PAN Diagnostic Models Have your office take necessary radiographs

Please indicate the general dentistry you have recommended to our mutual patient. This information will be used to support the patient's completion of definitive dentistry in your office. (Please list appropriate teeth.)

RECOMMENDED TREATMENT PLAN MAY INCLUDE:

Operative # _____ Endodontics # _____
Crowns # _____ Occlusal Therapy # _____
Fixed Bridge # _____ Extractions # _____
Removable Partial Denture _____ Questionable Prognosis # _____
Last recall/hygiene date _____ Next recall/hygiene date _____
Next dental appointment _____

APPOINTMENT STATUS:

An appointment was made by our office: Date: _____ Time: _____

Please circle the address below that is most convenient for the patient to have treatment.

_____ D.D.S.

Northside Office
14500 San Pedro #200
San Antonio, TX 78232
(210) 496-5603

New Braunfels Office
1583 E. Common St #200
New Braunfels, TX 78130
(800)442-5603

Babcock Office
2020 Babcock Rd. #20
San Antonio, TX 78229
(210) 496-5603