DENTAL IMPLANT SURGERY CENTER

You'll Love Your Smile!

"No-Cost" Consultation Form

Patient's Name: _____ Date: ____/____/____

Courtesy of Dr: _____

Daytime Phone: ( ) _____ Cell Phone: ( ) _____

Prior Treatment (if any): _____

_____

Prior Treatment Preformed in Month: _____ Year: _____

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

Reason for referring our valued patient:

- ☐ Periodontal Evaluation
- ☐ Dental Implants
- ☐ Extraction and Implants
- ☐ Extraction / Wisdom teeth
- ☐ Soft Tissue / Gum Grafting
- ☐ Crown Lengthening
- ☐ Orthodontic exposure
- ☐ Abscess / Incision-Drainage
- ☐ Bone Loss
- ☐ Bone Grafting
- ☐ Gingivectomy
- ☐ Frenectomy
- ☐ TMJ Disorder
- ☐ Biopsy / Stomatology
- ☐ Mucogingival Surgery
- ☐ Emergency

Other: _____

Doctor's comments: _____

Accompanying radiographs / Charting

☐ FMX ☐Peri-apical ☐ Panorex ☐ Perio Charting ☐Given to patient ☐Please take I-Cat series

Please fax to 972-665-1818…and thanks again for entrusting us with your surgical referrals!

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