

“No-Cost” Consultation Form

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

Courtesy of Dr: _____

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

Prior Treatment (if any): _____

Prior Treatment Performed 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:

- | | |
|--|---|
| <input type="checkbox"/> Periodontal Evaluation | <input type="checkbox"/> Bone Loss |
| <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Bone Grafting |
| <input type="checkbox"/> Extraction and Implants | <input type="checkbox"/> Gingivectomy |
| <input type="checkbox"/> Extraction / Wisdom teeth | <input type="checkbox"/> Frenectomy |
| <input type="checkbox"/> Soft Tissue / Gum Grafting | <input type="checkbox"/> TMJ Disorder |
| <input type="checkbox"/> Crown Lengthening | <input type="checkbox"/> Biopsy / Stomatology |
| <input type="checkbox"/> Orthodontic exposure | <input type="checkbox"/> Mucogingival Surgery |
| <input type="checkbox"/> Abscess / Incision-Drainage | <input type="checkbox"/> 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!