AUSTIN IMPLANTS &PERIODONTICS

CUONG HA DDS MS & ROBERT L MACHEN DDS MS

PATIENT _____ DATE _____

NUMBER _____ REFERRING DOCTOR _____

☐ PLEASE CALL PATIENT ☐ PATIENT WILL CALL

REASON FOR REFERRAL

☐ PERIODONTAL EVALUATION: ☐ FULL MOUTH ☐ SITE SPECIFIC

PERIO Tx COMPLETED IN YOUR OFFICE:

☐ SCALING ☐ PROPHY ☐ PERIO MAINTENANCE

RECALL INTERVAL _____ ESTABLISHED PATIENT SINCE _____

☐ IMPLANT EVALUATION _____

☐ EXTRACTION _____

☐ GINGIVAL GRAFTING _____

☐ ESTHETIC CROWN LENGTHENING _____

☐ CROWN LENGTHENING _____ IS TOOTH PREPARED? ☐YES ☐NO

ORTHODONTIC ASSIST

☐ EXPOSE AND BOND ☐ THIN GINGIVA/RECESSION

☐ OTHER

RESTORATIVE TREATMENT PLAN _____

_____

RADIOGRAPHS AVAILABLE: ☐ PANO ☐ FMX ☐ OTHER

OTHER REFERRALS: ☐ ENDO _____

☐ PROS _____

☐ ORTHO _____

PATIENT CONCERNS _____

ADDITIONAL COMMENTS _____

_____

PLEASE RETURN VIA MAIL OR:

EMAIL INFO@AUSTINIMPLANTS.COM FAX 512·693·0774