AR Periodontics, PC

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Appointment Information:
This time is reserved specifically for you. If by necessity, you must cancel your appointment, please notify us at least 48 hours in advance.

Patient's Name: _____

Appt. Date _____ Day _____ Time _____

Patients's Phone: _____(h) _____(w)

Referred By: _____

☐ Pre-medication required ☐ Patient is new to your practice

Please call us prior to consulting with patient ☐ Yes ☐ No

REMARKS OR SPECIAL INSTRUCTIONS

_____

_____

_____

_____

_____

PLEASE EVALUATE PATIENT FOR:

☐ Periodontal disease / Bone loss
☐ Crown lengthening #_____
☐ Soft tissue grafting #_____
☐ Guided tissue regeneration #_____
☐ Periodontal cosmetic surgery
☐ Dental Implants
☐ Surgical Extraction and socket preservation #_____
☐ Ridge augmentation #_____
☐ Root coverage #_____

Other _____

RADIOGRAPHS:

☐ Date of FMX _____
☐ FMX to be sent
☐ Patient has FMX
☐ Patient has PA of isolated area
☐ Please take PA of isolated area

RESTORATIVE THERAPY:

☐ Is planned (please comment)
☐ Will be planned after periodontal evaluation _____
☐ Is not indicated _____