CENTENNIAL PERIODONTICS & IMPLANTS

DR. KYLE LOSIN

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Date of Referral: ______________________________

Introducing: ________________________________

Patient Phone: ____________(h)___________(cell)

Referred By: ________________________________

Referring Dr.'s Tel. #:________________________

Patient has been in my practice for_______years.

☐ Patient is new to my practice

☐ Premedication required / antibiotic used

PLEASE EVALUATE FOR:

☐ Periodontal Disease / Full Mouth Examination

☐ Dental Implant(s) ☐ Extraction(s)

☐ Gingival Recession ☐ Soft Tissue Graft

☐ Ridge Augmentation ☐ Emergency Care

☐ Socket Preservation / Ovate Pontic

☐ Esthetic Crown Lengthening

☐ Functional Crown Lengthening

☐ Other:_________________________________

RADIOGRAPHS:

Date of most recent FMX: ____________________

Date of most recent Bitewings:_______________

☐ Radiographs will be sent

☐ Patient will bring radiographs

☐ Please take radiographs

RESTORATIVE THERAPY:

☐ Is planned (please comment below)

☐ Will be planned after periodontal evaluation

☐ Is not indicated

Please call prior to consulting with patient:

☐ Yes ☐ No

COMMENTS:

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