FAIRFAX PERIODONTAL GROUP
PERIODONTICS AND DENTAL IMPLANTS

Patient Name: _____
Date: _____
Referred By: _____
Office Number: _____

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Diplomate American Board of Periodontology

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Procedures | Consultation Requested

- ❑ Comprehensive Periodontal Evaluation
- ❑ Localized Evaluation # (s) _____
- ❑ Implant Therapy # (s) _____
- ❑ Crown Lengthening # (s) _____
- ❑ Soft Tissue Grafting # (s) _____
- ❑ Sinus/Ridge Augmentation# (s) _____
- ❑ Extraction # (s) _____
- ❑ 3D Imaging # (s) _____
- ❑ All-on-Four/Six Therapy - ❑ Upper ❑ Lower

Radiographs:

- ❑ We are sending available radiographs
- ❑ Patient is bringing radiographs to appointment
- ❑ No recent radiographs available

Communication:

- ❑ Please call me regading this patient
  - ❑ Before evaluation
  - ❑ After evaluation
- ❑ No need to call - written correspondence will suffice

Implant System Preference:

❑ Nobel Biocare ❑ BioHorizons
❑ Zimmer

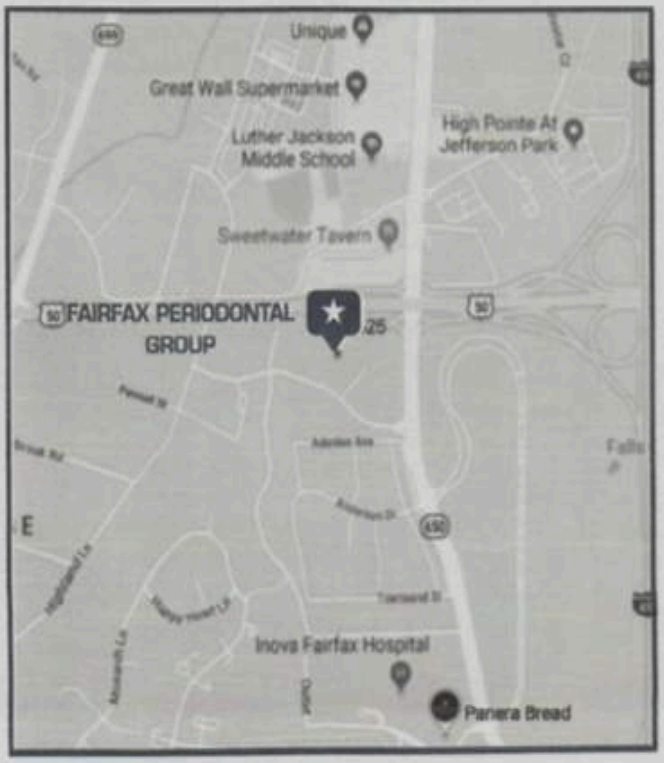
Special Instructions

_____
_____

Consultation

Please assist us on the day of your consultation appointment by providing the following:

- Referral
- List of medications you are currently taking
- Dental insurance forms | cards
- Any relevant radiograph x-rays and CT scans



Thank you for choosing Fairfax Periodontal Group for your periodontal and dental implant needs.

Our goal is to provide the highest quality of care in a state of the art environment that is both caring and informative.

Notes