DENT IMPLANT
SURGICAL SERVICES
CONVENIENCE • EXCELLENCE • COMPASSION

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Board-Certified Implant & Periodontal Surgeon

PATIENT INFORMATION

Patient's Name: ____________________ Date: ____________

Referred by Doctor: ____________________ Appointment Date: ____________

IMPLANT THERAPY

** Patient Must Have A CT Scan Available Prior To Implant Consult Appointment**

- ☐ Implant Placement (Site# ____________)
- ☐ Ridge Augmentation (Site# ____________)
- ☐ Extraction & Socket Preservation (Teeth # ____________)
- ☐ Other: ____________
- ☐ All on Four ("Fixed Denture") Therapy (Arch: ____________)
- ☐ Implant Supported Overdenture Therapy (Arch: ____________)
- ☐ Sinus Augmentation (Site# ____________)

ORAL SURGERY

- ☐ Wisdom Teeth Extraction (Teeth# ____________)
- ☐ Extraction (Teeth# ____________)
- ☐ Pre-Prosthetic Surgery-Alveoloplasty/Tori Removal (Area of Concern: ______)
- ☐ Other: ____________
- ☐ Soft/Hard Tissue Biopsy (Area of Concern: ____________)
- ☐ Canine Exposure & Bonding (Teeth# ____________)
- ☐ Oral/IV Sedation ____________

PERIODONTAL THERAPY

- ☐ Complete Periodontal Exam & Treatment
- ☐ Localized Periodontal Exam & Treatment
- ☐ Fotona Lightwalker® Perio Laser Therapy
- ☐ Periodontal Abscess (Teeth#____________)
- ☐ Crown Lengthening (Teeth#____________)
- ☐ Gingival Grafting (Teeth#____________)
- ☐ Gingivectomy (Teeth#____________)
- ☐ Frenectomy (Area of Concern: ____________)

Periodontal Therapy History: (Type of Therapy Completed by Referring Dentist)

- ☐ Initial Therapy (Date Completed: ____________)
- ☐ Periodontal Maintenance Therapy (Date Completed: ________)
- ☐ Never Had Therapy

Restorative Therapy:

- ☐ Is Planned (Please Comment Below)
- ☐ Will Be Planned After Periodontal Evaluation
- ☐ Is Not Indicated

Comments/Special Instruction:

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SNORING & SLEEP APNEA

Reason for Referral:

- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Not tolerating CPAP

Medical Justification (Patient has tried CPAP and has not tolerated and/or complied with treatment for the following reasons):

- ☐ Unable to tolerate mask/straps
- ☐ Unable to tolerate effective CPAP pressure
- ☐ N/A
- ☐ Skin sensitivity
- ☐ Claustrophobia
- ☐ Other Continuation of Care