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Periodontics & Implants
Phone 785-628-6733
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Introducing patient: ______________________________ Date of Birth: ______________

Referred by: ____

Patient's address ____
City State Zip

Patient's phone ____
Home Work Cell

What medical concerns does the patient have? ______________________________
____

Reason for referral: Limited Exam ___ Complete Exam ___ Implant Evaluation ___

Please cross out missing teeth and circle teeth that are a concern:

1	2	3	4	5	6	7	8	/	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	/	24	23	22	21	20	19	18	17

What specific dental concerns do you have? ______________________________
____
____

What periodontal treatment have you provided? ______________________________
____

What maintenance interval is the patient on? ______________________________

How compliant has the patient been relative to recommended dental treatment? Very ___ Moderately ___ Somewhat ___

What operative treatment does this patient require?
____

What prosthetic treatment does this patient require?
____

Send x-rays taken within the last 12 months if applicable. Date of last FMS, Pano and/or BWs______________

What specific concerns does the patient have? (motivation, time, finances, etc)
____

Additional Comments ____
____
____
____