MK PERIODONTICS AND IMPLANTS

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Referral from:

Date: _____

Introducing Patient: _____ DOB: _____

Email: _____ Phone Number: _____

Premedication Required: Check if YES ☐

Reason for Referral/Areas/Tooth Numbers:

_____

_____

☐ Comprehensive Exam ☐ Specific Area

☐ Pre prosthetic ☐ Pre orthodontic

Condition/Treatment

☐ Bacterial Sampling
☐ Scaling and Root Planing/GBT
☐ Periodontal Maintenance and Education
☐ Pocket Reduction
☐ Crown Lengthening
☐ Surgical Extraction
☐ Implants
System Choices: _____

☐ Peri implantitis/GBT
☐ Ridge Augmentation
☐ Sinus Lift
☐ Recession
☐ Frenectomy
☐ Gummy Smile
☐ Other: _____

We are committed to excellence in patient care. Thank you for your confidence and trust.

Your friends at

www.mkperio.com