

MK PERIODONTICS AND IMPLANTS

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Diplomates of the American Board of Periodontology



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Referral : _____ Date: _____

Introducing Patient: _____ DOB: _____

E-mail: _____ Phone Number: _____

Premedication Required: Check if YES Recent FMXR available: Check if YES

Reason for Referral/Areas/Tooth Numbers:

Comprehensive Exam

Limited Exam

Pre Prosthetic

Pre Orthodontic

Condition | Treatment:

- | | |
|---|---|
| <input type="checkbox"/> Initial Periodontal Therapy Guided BioFilm Therapy (GBT) | <input type="checkbox"/> Recession Root Coverage |
| <input type="checkbox"/> Periodontal Maintenance Therapy and Education | <input type="checkbox"/> LANAP Surgical Laser Therapy |
| <input type="checkbox"/> Osseous Surgery Pocket Reduction | <input type="checkbox"/> LAPIP Laser Peri-Implantitis Therapy |
| <input type="checkbox"/> Clinical Crown Lengthening Functional | <input type="checkbox"/> Ridge Augmentation |
| <input type="checkbox"/> Anterior Crown Lengthening Aesthetic | <input type="checkbox"/> Sinus Lift |
| <input type="checkbox"/> Surgical Extractions | <input type="checkbox"/> Botox Therapy Bruxism |
| <input type="checkbox"/> All on "X" Treatment All on 4 | <input type="checkbox"/> Oramyofunctional Therapy |
| <input type="checkbox"/> Dental Implant(s) | <input type="checkbox"/> Other: _____ |

Implant System Choice: _____

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