MK PERIODONTICS AND IMPLANTS

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Referring Doctor : _____ Date: _____

Introducing Patient: _____ DOB: _____

E-mail: _____ Phone Number: _____

Premedication Required: Check if **YES** ☐ **Recent FMX available**: Please email. Advise of SRP history.

Reason for Referral/Areas/Tooth Numbers and any restorative phasing information:

_____

_____

_____

_____

☐ **Comprehensive Exam** ☐ **Limited Exam**

☐ **Pre Prosthetic** ☐ **Pre Orthodontic**

Condition | Treatment:

☐ Initial Periodontal Therapy | Guided BioFilm Therapy (GBT)
☐ Periodontal Maintenance Therapy and Education
☐ Osseous Surgery | Pocket Reduction
☐ Clinical Crown Lengthening | Functional
☐ Anterior Crown Lengthening | Aesthetic
☐ Surgical Extractions
☐ All on "X" Treatment | All on 4
☐ Dental Implant(s)
Implant System Choice: _____

☐ Recession | Root Coverage
☐ LANAP | Surgical Laser Therapy
☐ LAPIP | Laser Peri-Implantitis Therapy
☐ Ridge Augmentation
☐ Sinus Lift
☐ Botox Therapy | Bruxism
☐ Oramyofuctional Therapy
☐ Other: _____

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