

PERIODONTAL SPECIALISTS

World-class care and caring

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PERIODONTAL REFERRAL

INTRODUCING _____

DATE _____ APPOINTMENT TIME _____

REFERRED BY _____

OFFICE PHONE _____

OFFICE/DOCTOR E-MAIL _____

EVALUATION AND TREATMENT OF:

PERIODONTAL CONDITION _____

DENTAL IMPLANT THERAPY _____

CROWN LENGTHENING _____

MUCO-GINGIVAL DEFECT/RECESSION _____

FRENECTOMY/FIBEROTOMY _____

SURGICAL EXPOSURE FOR ORTHODONTICS _____

GINGIVAL HYPERPLASIA _____

EXTRACTION _____

EXTRACTION/SOCKET PRESERVATION _____

RIDGE AUGMENTATION _____

ORAL PATHOLOGY/BIOPSY _____

TMJ AND BRUXISM _____

IV SEDATION _____

OTHER _____

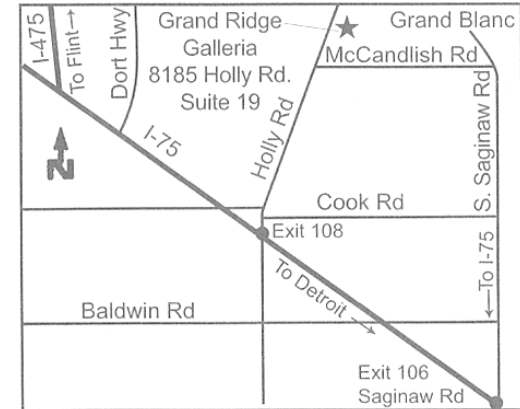
FULL MOUTH RADIOGRAPHS WILL BE SENT:

BY MAIL WITH PATIENT PLEASE TAKE

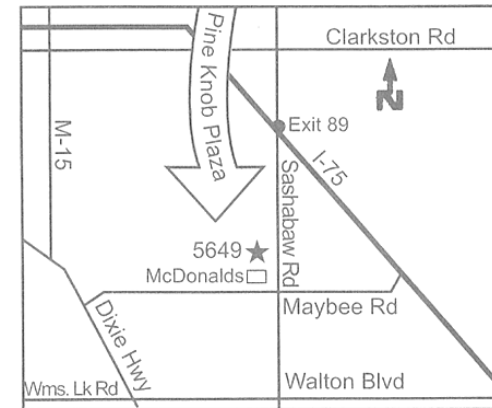
REMARKS _____

DO YOU HAVE SPECIFIC RESTORATIVE PLANS? _____

YOUR CONFIDENCE IN US IS GREATLY APPRECIATED!



GRAND BLANC OFFICE



CLARKSTON OFFICE