VIRUET PERIODONTICS
IMPLANTS - LASER THERAPY

34 Barkley Cir, Ft. Myers, FL 33907
Telephone: (239) 275-6564
FrontDesk@PeriodontistFortMyers.com

Date:_____

Patient's Name: _____ Phone#: _____

Referring Doctor: _____

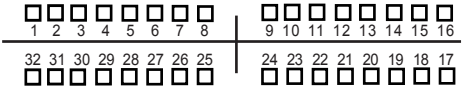
Appointment Date & Time: Monday _____ Time:_____ AM

****** 48 Hour notice is necessary if unable to honor appointment.***

☐ Please check if PREMEDICATION is required for dental appointments.

Referral for:

- ☐ Complete periodontal exam
- ☐ Specific area(s) of concern:
- ☐ Evaluation for laser-assisted periodontal procedures
- ☐ Esthetic crown lengthening: _____
- ☐ Functional crown lengthening: _____
- ☐ Recession / mucogingival defect: _____
- ☐ Pinhole procedure: _____
- ☐ Lip repositioning: _____



- ☐ Surgical extraction(s): _____
- ☐ Implant removal: _____
- ☐ Ridge augmentation bone graft (horizontal / vertical): _____
- ☐ Sinus lift: _____
- ☐ Dental implant: _____
- ☐ Peri-implantitis treatment: _____
- ☐ Tori / exostosis removal: _____
- ☐ Evaluation of pathology / biopsy area(s): _____
- ☐ Cone beam CT scan ☐ Panoramic
- ☐ IV sedation ☐ Oral sedation
- ☐ Emergency appointment: _____
- ☐ Other : _____

Restorative Treatment Plan: _____

_____

Pattern of Care: ☐ Regular ☐ Sporadic ☐ Little/None

Patient has received:

- ☐ Prophylaxis/ OHI _____ ☐ Patient of record since _____
- ☐ Root planing / initial therapy _____
- ☐ Previous periodontal therapy _____ ☐ New patient

X-rays. Type and date taken :

☐ to be e-mailed ☐ Patient will bring to appt ☐ Take at time of perio evaluation

Special concerns/comments:

☐ **Call me before evaluation of this patient** ☐ **Call me after evaluation of this patient**