



GOLDEN STATE
DENTAL

Diplomate of the American Board
of Periodontology

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First Available

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Introducing: _____ Date _____

From Dr. _____ Patient Phone # _____

PERIODONTAL CONCERN

- | | |
|--|---|
| <input type="checkbox"/> Complete Periodontal Examination..... | <input type="checkbox"/> Bone Graft..... |
| <input type="checkbox"/> Limited Periodontal Evaluation..... | <input type="checkbox"/> Gingival Augmentation..... |
| <input type="checkbox"/> Non-Surgical Treatment | <input type="checkbox"/> Gingivectomy..... |
| <input type="checkbox"/> Osseous Surgery | <input type="checkbox"/> Recession('s)..... |
| <input type="checkbox"/> Crown Lengthening ('s)..... | <input type="checkbox"/> Frenectomy..... |
| <input type="checkbox"/> Aesthetic Crown Lengthening..... | <input type="checkbox"/> Biopsy..... |
| <input type="checkbox"/> Extraction..... | <input type="checkbox"/> Orthodontic Exposures..... |

RADIOGRAPHS

- | | |
|--|--|
| <input type="checkbox"/> Emailed | CBCT: <input type="checkbox"/> Taken |
| <input type="checkbox"/> Please Take Radiographs | <input type="checkbox"/> Needed |
| | Surgical Guide Provided: |
| | <input type="checkbox"/> yes <input type="checkbox"/> no |

DENTAL IMPLANTS

- | | |
|---|---|
| <input type="checkbox"/> Implant Therapy | <input type="checkbox"/> Fixed Implant |
| <input type="checkbox"/> Full Arch Implant Therapy..... | <input type="checkbox"/> Implant removable..... |

•••• Special Instructions or Comments ••••

HYGIENE/PERIODONTAL MAINTENANCE

- Periodontist Alternating Referring Dentist



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