- Periodontics
- Laser Surgery
- Implants
- Sedation Dentistry

PA Sergio Corp

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Date: ______________________________

Patient Name: ______________________________

If Minor - Parent Name: ______________________________

Primary Phone Number: ______________________________

Secondary Phone Number (optional): ______________________________

Referred by: ______________________________

Dr.'s Phone Number: ______________________________

Appointment Date and time: ______________________________
Please give 2 working days notice if rescheduling is necessary.

Referral for:

- ❒ Complete Periodontal Exam - Full Mouth _____
- ❒ Implant Exam - Area: ____________________
- ❒ Emergency - Area of Discomfort: ____________
- ❒ Other: ______________________________
- ❒ Limited Periodontal Exam - Area: __________
- ❒ Gingival Recession/Graft - Area: __________
- ❒ Frenectomy - Area: ________________
- ❒ Patient may wish to consider treatment under Conscious Sedation.

If Patient has had any Perio treatment in your office (i.e. Root planing), please indicate procedure and dates below:

Comments or Special Concerns: ____

____

X-rays Provided: ❒ *FMX - Periapicals* ***(For a Complete Exam, Dr. Sergio will need FMX)***

❒ *BW* ❒ *PAN* ❒ *PA* ___ *Date of X-rays:* ____________________

Projected Restorative: ____

______________________________ *Please call me:* ❒ ***Before*** *or* ❒ ***After*** *patient is seen.*