

FROM: Dr. \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

Time: \_\_\_\_\_

**(a minimum of 2 business days advance notice is required for appointment changes)**

**EVALUATION FOR:**

- Emergency Treatment: # \_\_\_\_\_
- Specific Periodontal Problem: \_\_\_\_\_
- Complete periodontal evaluation: \_\_\_\_\_
- Crown Lengthening: # \_\_\_\_\_
- Cosmetic periodontal treatment: \_\_\_\_\_
- Dental Implants: \_\_\_\_\_
- Other: \_\_\_\_\_

**AVAILABLE RADIOGRAPHS**

- Periapicals: No. of films: \_\_\_\_\_ Date: \_\_\_\_\_
- Full Mouth Series: \_\_\_\_\_ Date: \_\_\_\_\_
- Panorex: \_\_\_\_\_ Date: \_\_\_\_\_
- are enclosed  patient will bring
- have been mailed  return patient for x-rays
- will be sent  take and send duplicate x-rays
- Please call during the initial patient consultation