



Patient Details

Name: DOB: Tel:

Address:

Referred for

- | | |
|--|---|
| <input type="checkbox"/> Implant placement (type | <input type="checkbox"/> Tissue grafting (soft/hard) |
| <input type="checkbox"/> Implant prosthetics yes / no | <input type="checkbox"/> Frenectomy |
| <input type="checkbox"/> Removal of teeth/roots/implant | <input type="checkbox"/> Crown lengthening/Gingivectomy |
| <input type="checkbox"/> Periodontal disease/Peri-implant disease
(Shared maintenance yes / no) | <input type="checkbox"/> Tooth exposure |
| | <input type="checkbox"/> Recession treatment |

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Other/Comments:

Radiographs

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> enclosed | <input type="checkbox"/> none available |
| <input type="checkbox"/> emailed | <input type="checkbox"/> patient will bring |

Referring Doctor - business card/stamp

.....
Signature

.....
Date

