North Dallas Periodontics & Implant Center
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Date: _______________ Referring Dr.: ____________________

Patient: ________________________ Patient DOB: ____________

_____ Please call patient _____ Patient will call for appointment

Patient Phone: ________________________

Please Evaluate Patient For:

□ Complete Periodontal Evaluation

Has the Patient Received Quadrant Scaling & Root Planning? __ Yes __ No

If yes, when? ____________________

□ Limited Periodontal Evaluation Area: ______________

□ Crown Lengthening Tooth/Teeth #: ______________

□ Gingival Recession Area('s): ______________

□ Mucogingival Defect Area('s): ______________

□ Implant Consultation Tooth/Teeth #: ______________

□ Other: ____

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Did the patient have x-rays taken that you can provide? ___ Yes ___ No

□ FMX □ PANO □ BW □ PA('s) Date Taken: ______________

_____ Accompanying patient _____ Emailed to our office

Are you requesting a Cone Beam CT? ___ Yes ___ No

We offer same day appointments for emergency care.