SCHOLES
PERIODONTICS & IMPLANTS

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Appointment

Date:

Time:

Digital x-rays will be taken for diagnostic purposes at our office.
Thank you.

INTRODUCING: _____
(Patient Name)

Referred by Doctor: _____ Date _____

Please consult / treat regarding:

- ❑ Periodontal Evaluation
- ❑ Periodontal Pain or Hypersensitivity
- ❑ Mucogingival problem
- ❑ 3-D Cone Beam CT Scan

- ❑ Dental Implants
  - ❑ All on4
  - ❑ Maxilla
  - ❑ Mandible
  - ❑ Bar OD or Locator OD

❑ Other: _____

Areas of concern are:

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Comments: _____

Please see map on back.