



DAVID J. ADAMS, DMD, MS, PA

Periodontics & Implant Dentistry

*Diplomate of the American Board of Periodontology*

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Date: \_\_\_\_\_

Referring Dr.: \_\_\_\_\_

Patient name: \_\_\_\_\_

Patient address: \_\_\_\_\_

Patient home phone: \_\_\_\_\_

Patient work phone: \_\_\_\_\_

**Instructions for Dr. Adams and staff**

- An appointment is scheduled on \_\_\_\_\_
- Please call patient
- Patient will call

**Radiographs**

- Dr. Adams to take
- FMX being sent
- Prior x-ray available

**Restorative Treatment**

- Is complete
- Is established
- Is pending outcome of periodontal findings

**Please evaluate for:**

- Generalized Periodontal Disease \_\_\_\_\_
- Localized Periodontal Disease # \_\_\_\_\_
- Crown Lengthening # \_\_\_\_\_
- Recession # \_\_\_\_\_
- Esthetic Gingival Contouring # \_\_\_\_\_
- Extraction/Ridge Preservation # \_\_\_\_\_
- Ridge Augmentation (Hard/Soft) # \_\_\_\_\_
- Sinus Lift \_\_\_\_\_
- Endosteal Dental Implant # \_\_\_\_\_
- Canine Exposure # \_\_\_\_\_
- Frenectomy \_\_\_\_\_
- Sedation: IV / Oral / N<sub>2</sub>O+O<sub>2</sub> \_\_\_\_\_

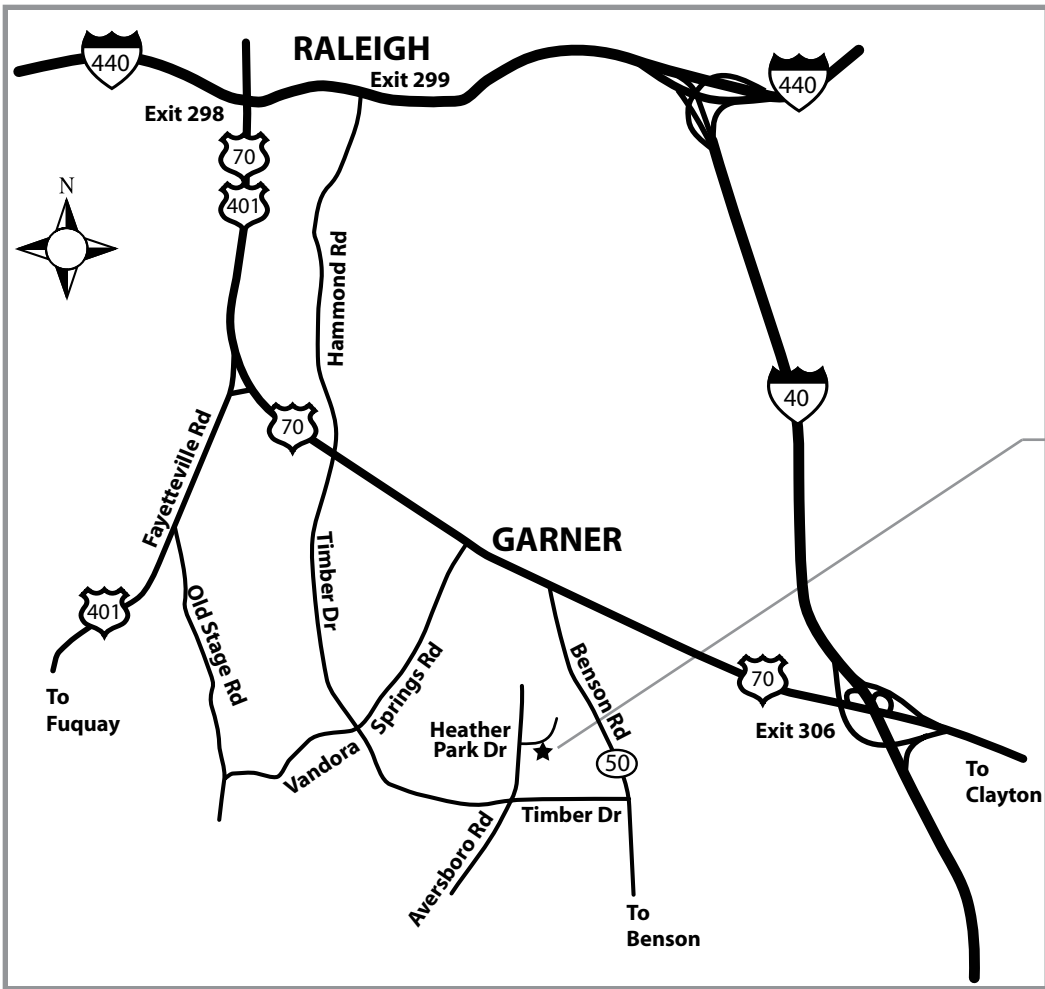
**Other/Comments:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Periodontal Therapy in office to date:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Please fax this completed form to our office and your patient will be contacted for an appointment.**



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