ALAMEDA PERIO +IMPLANT CENTER

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Patient Name _____ DOB _____

Dental Insurance/Subscriber ID _____

Please send all x-rays to: info@alamedaperio.com

Referring Dr. _____ Appt . Date / Time _____

Patient Phone # _____ Patient Email _____

RADIOGRAPHS:

❑ Emailed Sent with Patient Please Take Date _____

PLEASE CIRCLE AREA OR TEETH IN QUESTION

UR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	UL
LR	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LL

I AM REFERRING THIS PATIENT FOR:

❑ Complete Perio. Eval. **(FMX REQUIRED)**
❑ Limited Perio. Eval.
❑ Implant(s)
❑ All - on - X
❑ Biopsy
❑ Emergency
❑ Extraction(s)
❑ Frenulectomy
❑ LANAP (Laser-Assisted New Attachment Procedure)
❑ Peri-implantitis
❑ Scaling & Root Planing (SRP)
❑ Soft Tissue Grafts
❑ Sinus Augmentation
❑ Other _____

SPECIAL INSTRUCTIONS OR COMMENTS: