Metro East Dental Implants & Periodontics
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P: (618) 258-1244 F: (618) 258-1295

From: _____ Date: _____

Patient Name: _____ Phone: _____

Requires Pre-Medication? ☐ Yes ☐ No. Reason for Pre-Med: _____

REASON FOR REFERRAL:

☐ Comprehensive Periodontal Evaluation ☐ Peri-Implantitis: Site(s): _____

☐ Implants: Site(s): _____ Preferred Implant System: ☐ Zimmer ☐ Straumann

☐ Aesthetic / Functional Crown Lengthening: Site(s): _____

☐ Gingival Recession / Root Coverage / Mucogingival Defects: Site(s): _____

☐ Other:_____

RADIOGRAPHS:

Most recent radiographs taken: ☐FMS ☐ BWs Date: _____

☐ Radiographs are being mailed ☐ Patient is bringing Radiographs

☐ Radiographs are being emailed ☐ Please take Radiographs and forward a copy

Comments:

_____

_____

_____

Restorative Treatment Plan:

_____

_____

_____