altura
PERIODONTICS
& DENTAL IMPLANTS
THE HEIGHT OF TREATMENT

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Patient _____ Tel No. _____ Date _____

❑ Comprehensive Periodontal Evaluation

❑ Isolated Evaluation for area _____

❑ Implant Consultation_____

Root planing and scaling performed on (dates): UR _____ UL _____ LL _____ LR _____

❑ Please call me prior to seeing patient. ❑ Please call me after seeing patient.

Areas of Concern and Restorative Dentistry Treatment Plan: _____

_____

_____

❑ I will provide an FMX for a comprehensive evaluation OR limited radiographs for an isolated evaluation.

❑ Please take FMX/Pano and send to our office with the follow up letter.

❑ Insurance Company_____

Referred by Dr. _____ Tel No. _____

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