

# MK PERIODONTICS AND IMPLANTS

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## REFERRAL

Referred by: \_\_\_\_\_ Date: \_\_\_\_\_

Introducing Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Email: \_\_\_\_\_ PH (H): \_\_\_\_\_

PH (W): \_\_\_\_\_ Cell: \_\_\_\_\_

FOR THE FOLLOWING  
(check all that apply)

### EXAMINATION

- Comprehensive
- Specific
- CBCT Scan

Tooth Number(s): \_\_\_\_\_

### TREATMENT

- Extraction
- Ridge Augmentation
- All on Four
- Implant Overdenture
- Sinus Lift
- Implants
  - Trauma
  - Past/Recent
  - Non-Restorable
- Preferred Implant System
  - Nobel Biocare
  - Straumann
  - Hiossen
  - No Preference
- Gingival Augmentation for lack of Gingiva
- Root Coverage
- Gummy Smile Correction
- Crown Lengthening
- Pocket Reduction
- Bone Graft/GTR
- Pre-Ortho Evaluation
- Ortho Exposure
- Frenectomy
- Other

Pre-Med/Joint Replacement: \_\_\_\_\_

Restorative Plan: \_\_\_\_\_

Hx of Sc/Rp if performed: \_\_\_\_\_

Length of time in your practice: \_\_\_\_\_

How many cleaning sessions/year? \_\_\_\_\_

Dear Patient: Your first appointment at our office will be an examination. We will provide diagnosis of your periodontal health, evaluate your X-rays, and determine the extent of involvement and share with you our recommendations. We will also review fees, insurance coverage - including possibility of medical coverage as well as payment options.

We are committed to excellence in patient care. Thank you for your confidence.

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