AUGUSTA PERIODONTICS & IMPLANTS

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Please FAX to (706) 863-0087 and Give Referral Form to Patient

Patient Information

Name: Mr./Ms./Mrs./Dr. _____

Telephone: _____

E-Mail: _____

Referring Doctor

Name: Dr. _____

E-Mail: _____

Areas of Concern

- O Single Tooth _____
- O Multiple Teeth _____
  - O Periodontal Disease
  - O Recession Treatment
  - O Crown Lengthening
  - O Guided Tissue Regeneration
  - O Extraction/Graft
  - O Dental Implants
  - O Sinus Augmentation
  - O Ridge Augmentation
  - O Tooth Exposure
  - O PAOO
  - O Biopsy
  - O Frenectomy
  - O Gingivectomy
  - O CBCT Scan

Restorative Plans

1. _____
2. _____
3. _____
4. _____

Pre-Treatment Information

Please email all digital radiographs to office@augustaperiodontics.com

- O FMX
- O PAs
- O BWX
- O PANO
- O CBCT

Periodontal Treatment Completed in Your Office

- O Debridement
- O Scaling and Root Planing
- O Periodontal Maintenance

Notes

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