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PATIENT INFORMATION

Patient's Name _____ Date _____

☎ Primary _____ Secondary _____ Date of Birth _____

Referring Office/Doctor _____

PERIODONTAL THERAPY

Please Indicate Tooth Number

- ☐ Comprehensive Exam & Treatment
- ☐ Limited Exam & Treatment _____
- ☐ Crown Lengthening _____
- ☐ Gingivectomy _____
- ☐ Soft Tissue Grafting _____
- ☐ Pocket Reduction _____
- ☐ Periodontal Bone Grafting _____
- ☐ Other _____

IMPLANT THERAPY

- ☐ Extraction & Site Preservation _____
- ☐ Implant Placement (Sites:_____)
- ☐ Immediate Implant Placement & Provisional Crown (Sites:_____)
- ☐ Sinus Augmentation _____
- ☐ Ridge Augmentation _____
- ☐ Other _____

OTHER SERVICE

- ☐ Extractions _____
- ☐ Pre-Prosthetic Surgery _____
- ☐ Soft/Hard Tissue Biopsy _____
- ☐ Tooth Exposure for Orthodontics _____
- ☐ Frenectomy _____
- ☐ Orthodontic Mini Implants _____
- ☐ Fiber Release _____
- ☐ Other _____

RECENT FULL MOUTH RADIOGRAPHS

- ☐ Patient will bring
- ☐ Emailed to office
- ☐ Mailed to office
- ☐ New Radiographs Needed

Comments _____

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X-Rays can be sent to perio@madisonfamilydental.com
Please fax referral to 608-274-0791 Madison or 608-846-2354 DeForest

Madison Family Dental Associates, S.C.