BLUEGRASS PERIODONTICS & IMPLANT DENTISTRY

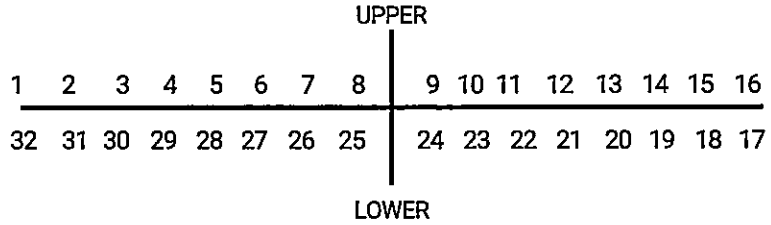
Today's Date _____

Patient Name _____ Phone _____

Patient Email _____

Referring Dentist _____ Phone _____

AREA TO BE TREATED



TREATMENT NEEDED

- ☐ Periodontal Evaluation/Pockets
- ☐ Scaling and Root Planing (SRP)
- ☐ Osseous Surgery
- ☐ Extraction/Ridge Preservation
- ☐ Dental Implant(s)
- ☐ Peri-implantitis
- ☐ Sinus Grafting
- ☐ Bone Grafting (Ridge Augmentation)
- ☐ Gum Grafting (Recession)
- ☐ Cosmetic Crown Lengthening (Gummy Smile)
- ☐ Functional Crown Lengthening (Restorative)
- ☐ Frenectomy
- ☐ Apico/Root Amputation
- ☐ Tooth Exposure/Bracket Placement
- ☐ Wilckodontics (PAOO)
- ☐ Biopsy (Pathology)
- ☐ Cone Beam CT
- ☐ All-On-X (Teeth In a Day)
- ☐ IV Sedation
- ☐ Other _____

HYGIENE TREATMENT HISTORY

- ☐ Prophy completed (Date) _____ Scheduled for _____ month recall
- ☐ Maintenance completed (Date) _____ Scheduled for _____ month recall
- ☐ SRP completed (Date) _____ Scheduled for _____ month recall
- ☐ Recent X-rays (Date & Type) _____ Scheduled for _____ month recall

CONSULTATION SCHEDULED FOR Day _____ Date _____ Time _____ : _____ am / pm

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