



Old Orchard
Periodontics and Implant Dentistry, Ltd.

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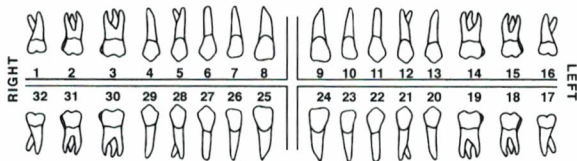
Patient's name: _____

Please evaluate for:

- Implant(s) _____
- Crown Lengthening _____
- Gingival recession _____
- Management of Periodontal Disease ___
- Other _____

Appointment: _____

- Please call me
- Take Full Set of X-rays
- Take Panoramic
- Take Cone Beam CT



Comments _____

Date: _____

Referred By Dr. _____ Tel. No. _____

