Practice Limited to Periodontics & Implant Surgery

Black Beagle SM DMD DDS MSD

dentistry meets aesthetics

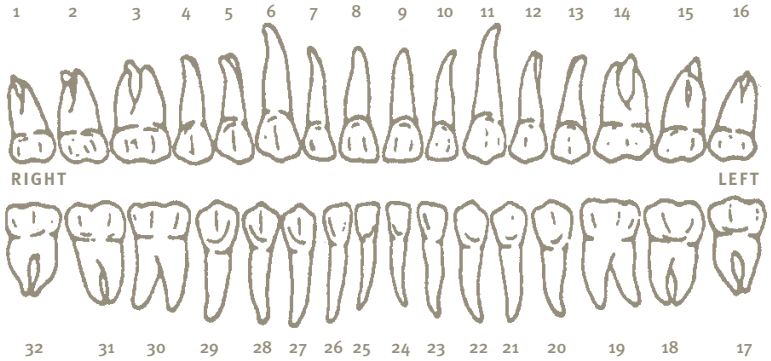
Referred by _____ **Date** _____

Introducing _____ **DOB** _____

Parent(s) Name (if patient is a minor) _____

○ Patient will be contacting your office. ○ Please contact this patient by phone: _____

Please evaluate and treat the following teeth:



○ Please perform a comprehensive exam.

○ Please perform a limited exam for: _____

○ Patient has completed initial therapy and requires surgical evaluation for: _____

Please evaluate for:

- ○ periodontal bone regeneration
- ○ crown lengthening
- ○ guided bone regeneration
- ○ exposure of impacted tooth
- ○ extraction
- ○ soft tissue graft
- ○ root coverage autograft
- ○ edentulous ridge augmentation
- ○ root resection
- ○ frenectomy
- ○ other: _____

○ Please evaluate for endosseous implant(s).

Area: _____

Initial Thoughts on Restorative Treatment Plan: _____

_____

Patient's Primary Concern(s): _____

_____

Comments: _____

_____

_____

3003 East 98th St, Suite 200 | Indianapolis, IN 46280 | *tele* 317.843.1281 | *fax* 317.574.9390 | *www.*BlackBeagleDDS*.com*

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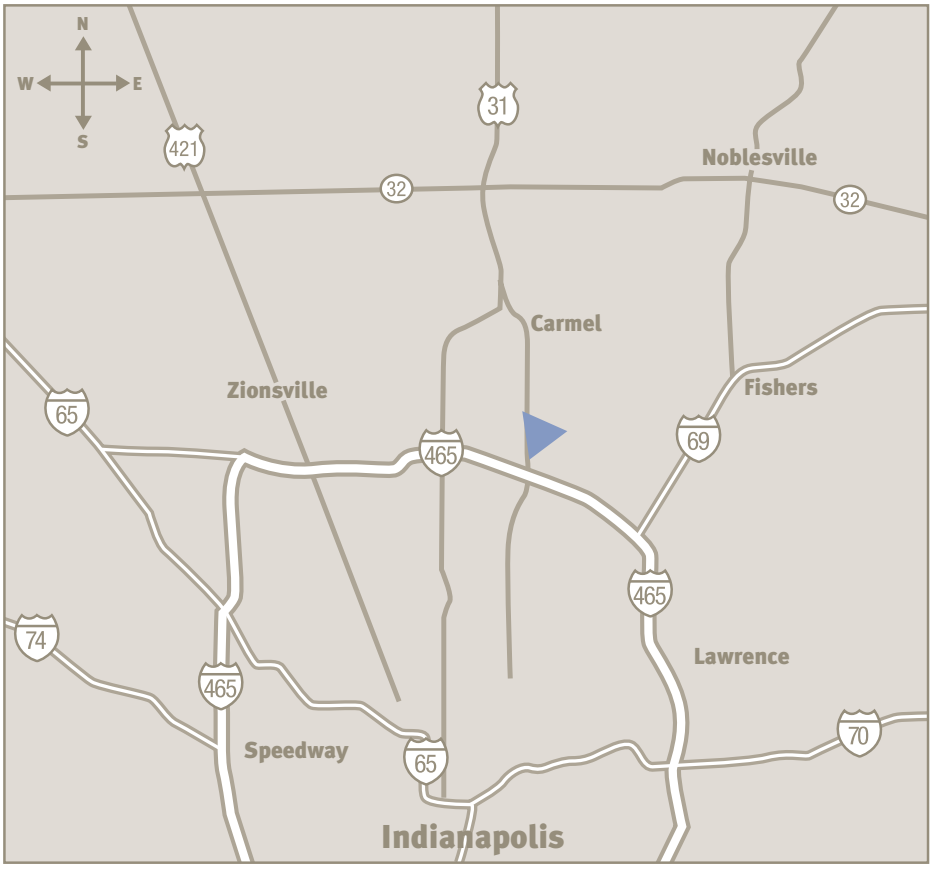

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