SOUTHWEST FLORIDA PERIODONTICS, LLC

Tyler M. Blackenburg, DMD *Dental Implants / Periodontics / Dental Rehabilitation*

14575 Tamiami Trail, Unit A • North Port, Florida 34287 • Phone: (941) 888-2362 • Fax: (941) 888-5296

Email: SouthwestFloridaPeriodontics@gmail.com • Web: drtylerblackenburg.com

Date: _____ Introducing: _____

Patient Phone Number: _____ Time/Date of Appointment: _____

Referring Doctor Name: _____

Referring Doctor Phone Number/E-mail: _____

FOR PROCEDURE AS FOLLOWS:

- ☐ Comprehensive Full Mouth Examination
- ☐ Isolated Areas: _____
- ☐ Esthetic Crown Lengthening: _____
- ☐ Crown Lengthening/Root Reshaping: _____
- ☐ Gingival Grafting: _____
- ☐ Bone Augmentation: _____
- ☐ Periscopy:(EAPT - Endoscope Assisted Periodontal Therapy) _____
- ☐ Dental Implant Evaluation: _____
- ☐ Other: _____

SUPPORTIVE PERIODONTAL THERAPY (SPT) HISTORY:

Patient Compliance ☐ Regular ☐ Sporatic Recall Schedule Every _____ Months

PREVIOUS PERIODONTAL TREATMENT: ☐ None ☐ Maintenance Only

☐ Scaling / Root Planing

☐ UR ☐ UL ☐ LL ☐ LR Date Completed: _____

☐ Periodontal Surgery

☐ UR ☐ UL ☐ LL ☐ LR Date Completed: _____

☐ Other: _____

RADIOGRAPHS: ☐ to be E-mailed accompanied with patient mailed prior to appointment

☐ Take as needed

SPECIFIC RESTORATIVE PLANS: I am planning the following restorative (or other) treatment: _____

_____

_____

UPON COMPLETION OF ACTIVE PERIODONTAL THERAPY, I WOULD PREFER TO:

☐ Ask you to do all necessary scaling for periodontal maintenance ☐ Alternate periodontal maintenance with you

SPECIAL INSTUCTIONS: ☐ Medical ☐ Complications ☐ Premed ☐ Other _____

_____

_____

ADDITIONAL COMMENTS / PATIENT CONCERNS

_____

_____

_____

_____

_____

_____

_____

_____