



# 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:

- |  |  |
|--|--|
| <input type="checkbox"/> Comprehensive Full Mouth Examination                            | <input type="checkbox"/> Isolated Areas: _____                   |
| <input type="checkbox"/> Esthetic Crown Lengthening: _____                               | <input type="checkbox"/> Crown Lengthening/Root Reshaping: _____ |
| <input type="checkbox"/> Gingival Grafting: _____  | <input type="checkbox"/> Bone Augmentation: _____                |
| <input type="checkbox"/> Periscopy:(EAPT - Endoscope Assisted Periodontal Therapy) _____ |  |
| <input type="checkbox"/> Dental Implant Evaluation: _____                                |  |
| <input type="checkbox"/> Other: _____  |  |

## SUPPORTIVE PERIODONTAL THERAPY (SPT) HISTORY:

Patient Compliance ☐ Regular ☐ Sporadic Recall Schedule Every \_\_\_\_\_ Months

## PREVIOUS PERIODONTAL TREATMENT: ☐ None ☐ Maintenance Only

- |   |                       |
|---|-----------------------|
| <input type="checkbox"/> Scaling / Root Planing   |                       |
| <input type="checkbox"/> UR <input type="checkbox"/> UL <input type="checkbox"/> LL <input type="checkbox"/> LR | Date Completed: _____ |
| <input type="checkbox"/> Periodontal Surgery  |                       |
| <input type="checkbox"/> UR <input type="checkbox"/> UL <input type="checkbox"/> LL <input type="checkbox"/> LR | Date Completed: _____ |
| <input type="checkbox"/> 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 INSTRUCTIONS:** ☐ Medical ☐ Complications ☐ Premed ☐ Other \_\_\_\_\_

## ADDITIONAL COMMENTS / PATIENT CONCERNS

