



# SOUTHWEST FLORIDA PERIODONTICS, LLC

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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  Sporadic 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 INSTRUCTIONS:**  Medical  Complications  Premed  Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## ADDITIONAL COMMENTS / PATIENT CONCERNs

\_\_\_\_\_  
\_\_\_\_\_  
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