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www.csperiodontics.com

Patient Name: _____ DOB: _____

Patient Phone #: _____ Referral Date: _____

Referring Dr. _____ Office Phone #: _____

Procedure

- ☐ Gingival Inflammation
- ☐ Crown Lengthening
- ☐ Soft Tissue Grafting
- ☐ IV Sedation
- ☐ Implant
- ☐ 3D Cone Beam
- ☐ Sinus Augmentation
- ☐ Ridge Augmentation
- ☐ Extraction
- ☐ Ridge Preservation
- ☐ Alveoplasty
- ☐ Tori Removal
- ☐ Frenectomy
- ☐ Expose & Bond
- ☐ Fiberotomy

Please Circle Area To Be Treated

UR Area								UL Area							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
LR Area								LL Area							

Surgical Template

- ☐ To be provided by restorative dentist
- ☐ To be fabricated by surgeon
- ☐ Other _____

Radiographs

- ☐ Being mailed / E-mailed
- ☐ Hand carried by patient
- ☐ Please take

Comments and Special Instructions:

_____

_____

_____

_____

Please fill out this form and fax or email to the most convenient location for your patient:

Edinburg Office: (956) 627-0668

info@csperiodontics.com

Thank You So Much For Allowing Us To Share In the Care Of Your Patients!