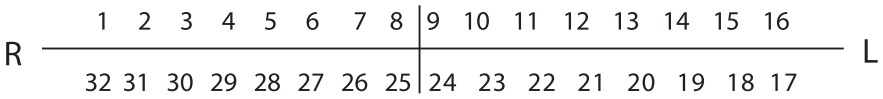
SOCALDSC

Practice limited to ***Periodontics***

Patient's Name: _____ Date _____ for

- ☐ Periodontal Consultation / Treatment
- ☐ Gingival Graft
- ☐ Crown Lengthening Procedure
- ☐ Aesthetic Surgery Evaluation
- ☐ TMJ / Orofacial Pain Evaluation
- ☐ Oral Implant / Preprosthetic Surgery Evaluation
- ☐ Biopsy / Oral Pathology Evaluation



Appointment Time: _____ Time: _____ A.M. P.M.

Chief Complaint: _____

Special Instruction / Remarks: _____

_____

Current X-ray: ☐ Sent by mail ☐ Sent with Patient ☐ Please take one ☐ Please return

Referred by DR: _____

PLEASE BRING THIS CARD WITH YOU, THANK YOU.