

PLEASE GIVE A COPY OF THIS FORM TO PATIENT AND SEND A COPY TO OFFICE OF JODY SCHILLING, DDS (FAX PREFERRED)

TODAY'S DATE _____
PATIENT FIRST NAME _____ PATIENT LAST NAME _____
PHONE _____ E-MAIL _____
REFERRED BY _____ PHONE/E-MAIL _____

APPOINTMENT

- APPOINTMENT CONFIRMED FOR DATE/TIME _____
Dear Patient: This time is reserved specifically for you. 48 hours advance notification is required for any cancellation.
CONTACT PATIENT FOR APPOINTMENT
NOTE: We will contact the patient within two business days of receipt, unless specifically instructed to wait for patient's call.

PERIODONTAL SERVICES

- PERIODONTAL EVALUATION
PATIENT HAS HAD SRP IN LAST 24 MONTHS
RECALL CYCLE _____
PATIENT HAS HAD ARESTIN TREATMENT
PERIODONTAL DISEASE
GENERALIZED LOCALIZED # _____
VERTICAL (INFRABONY) DEFECT GRAFTING # _____
SOFT TISSUE GRAFTING # _____
CROWN LENGTHENING # _____
BIOPSY _____
FRENECTOMY _____
GINGIVECTOMY _____
EXPOSURE OF IMPACTED TEETH IN CONJUNCTION WITH
ORTHODONTIC THERAPY # _____

DENTAL IMPLANT SERVICES

- EXTRACTION # _____
RIDGE AUGMENTATION # _____
IMPLANT PLACEMENT # _____
PREFERRED IMPLANT SYSTEM _____
SINUS AUGMENTATION # _____
IMPLANT REPAIR/COMPLICATION # _____

OTHER

RESTORATIVE TREATMENT PLAN

- IS PLANNED COMMENT _____
WILL BE PLANNED AFTER PERIODONTAL EVALUATION

AVAILABLE RADIOGRAPHS

- FMX DATE _____ PAN DATE _____ PA'S DATE _____ BW'S DATE _____ CBCT DATE _____
WILL BE E-MAILED TO frontdesk@schillingperio.com (PREFERRED)
WILL BE POSTAL MAILED TO OFFICE OF JODY SCHILLING, DDS
ARE BEING SENT WITH PATIENT
NONE AVAILABLE

PRE-MEDICATION REQUIRED

SPECIAL INSTRUCTIONS/NOTES

