



Today's Date: _____

Patient's Name: _____

Phone: _____ Email: _____

Referral by: _____

Radiographs: Given to Patient _____ Emailed _____ Please Take New _____

PLEASE MARK TEETH TO BE TREATED

UPPER																	
R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
LOWER																	

REFERRED FOR:

- | | |
|---|---------------------------------------|
| ☐ Comprehensive Perio Evaluation | ☐ Gummy Smile |
| ☐ Crown Lengthening | ☐ SFOT |
| ☐ Dental Implants | ☐ Sinus Lift |
| ☐ Extractions | ☐ Other: _____ |
| ☐ Gum Recession | |

Special Instructions: _____

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