trillium

DENTAL CARE

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Board Certified Periodontist

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Patient Name: _____ Phone No: _____

Patient DOB : _____ Patient Insurance Carrier :_____

Referring Doctor Name: _____

Please indicate reason for visit and the teeth or quadrants involved:

- ☐ Periodontal Evaluation Only
- ☐ Bone Graft
- ☐ Implant
- ☐ Canine Exposure
- ☐ Frenectomy
- ☐ IV Sedation/Oral Sedation
- ☐ Crown Lengthening
- ☐ Gingivectomy
- ☐ Other_____
- ☐ TMJ/Migraine Consultation
- ☐ Neuromuscular/Botox
- ☐ Extractions
- ☐ Soft Tissue Grafting/Root Coverage
- ☐ Osseous Surgery/Pocket Reduction
- ☐ TAD (temporary anchorage device)
- ☐ Biopsy
- ☐ Tooth #(s)_____
- ☐ Quads: _____

Radiographs will be:

☐ Sent to info@trilliumdentalcare.com ☐ Sent with patient ☐ Need to be exposed

Restorative Plans Include:

_____

_____

_____

Please ☐call or ☐text patient to schedule appointment at this number: _____

☐This patient will call your office to schedule appointment

☐This patient has an appointment on _____