TAMPA BAY
DENTAL IMPLANTS + PERIODONTICS PL

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We Appreciate Your Referrals!

Date _____

Introducing _____

Telephone _____

Appointment Date _____ Time _____

Referred by _____

Telephone _____

Patient has been in my practice for ____ Years ____ Months

☐ Patient is new to my practice

Please call prior to consulting with patient ☐ Yes ☐ No

☐ Emergency ☐ Full Mouth ☐ Local Care Only

Specific Areas

			a	b	c	d	e	f	g	h	i	j			
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
			t	s	r	q	p	o	n	m	l	k			

PATIENT HAS RECEIVED:

☐ PROPHY DATE _____
☐ SCALING & ROOT PLANING DATE _____
☐ PREVIOUS PERIO THERAPY DATE _____

RADIOGRAPHS: DATE _____

☐ FMX ☐ PANO

☐ PATIENT WILL BRING ☐ EMAILED
☐ WE HAVE MAILED THEM ☐ TAKE AT TIME OF EXAM

PLEASE EVALUATE FOR:

☐ CT SCAN
☐ ORAL PATHOLOGY/BIOPSY
☐ SOFT TISSUE GRAFT/RECESSION
☐ BONE GRAFT
☐ PREPROSTHETIC SURGERY
☐ OSSEOUS/POCKET ELIMINATION SURG.
☐ IMPLANTS
☐ CROWN LENGTHENING
☐ COSMETIC SURGERY
☐ GUMMY SMILE
☐ FRENECTOMY/FIBEROTOMY
☐ CANINE/TOOTH EXPOSURE
☐ GINGIVAL HYPERPLASIA

RESTORATIVE TREATMENT PLAN:

☐ IS PLANNED (PLEASE COMMENT)
☐ WILL BE PLANNED AFTER PERIO EVAL
☐ NOT INDICATED

COMMENTS OR OTHER CONCERNS:

INFORMATION FOR PATIENTS

WELCOME TO OUR PERIODONTAL OFFICE!

OUR OFFICE IS COMMITTED TO PROVIDING YOU WITH THE HIGHEST QUALITY OF CARE POSSIBLE. IT IS OUR GOAL TO WORK CLOSELY WITH YOUR DOCTOR TO PROVIDE YOU WITH THE BEST DENTAL CARE. OUR ENTIRE STAFF LOOKS FORWARD TO A PLEASANT AND PERSONAL RELATIONSHIP WITH YOU.

THE INITIAL VISIT, WITH THE EXCEPTION OF CERTAIN CASES IS FOR EXAMINATION/X-RAYS ONLY. THIS VISIT ALLOWS US TO FULLY EVALUATE YOU, ANSWER ANY QUESTIONS AND TAILOR YOUR TREATMENT PLAN TO YOUR SPECIFIC NEEDS.
AFTER THE EXAMINATION, YOU WILL BE INVITED BACK FOR A CONSULTATION.
PLEASE BRING ALL PERTINENT MEDICAL INFORMATION INCLUDING NAMES AND PHONE NUMBERS TO YOUR PHYSICIANS AND DENTISTS.

IF YOU ARE CURRENTLY TAKING ANY MEDICATION, PLEASE DO NOT STOP UNLESS YOUR DOCTOR HAS TOLD YOU TO DO SO PRIOR TO YOUR APPOINTMENT.
BE SURE TO BRING A LIST OF NAMES AND DOSES OF ALL MEDICATIONS THAT YOU ARE TAKING.
IN ADDITION, PLEASE BRING A LIST OF NAMES AND REACTIONS TO MEDICATIONS THAT YOU ARE ALLERGIC TO.

PAYMENT IS DUE WHEN SERVICES ARE RENDERED (CASH, VISA/MASTERCARD).
WE WILL BE HAPPY TO FILE WITH YOUR INSURANCE COMPANY FOR REIMBURSEMENT.
IF YOU PLAN TO USE INSURANCE, PLEASE BRING A COPY OF YOUR INSURANCE CARD AND/OR THE COMPANY'S TELEPHONE NUMBER. THIS WILL ALLOW US TO VERIFY YOUR INSURANCE COVERAGE.

YOUR APPOINTMENT IS RESERVED SPECIFICALLY FOR YOU. IF BY NECESSITY, YOU MUST CANCEL YOUR APPOINTMENT, PLEASE NOTIFY US AT LEAST **48 HOURS** IN ADVANCE.

FINALLY, THANK YOU FOR USING US FOR YOUR IMPLANT/PERIODONTAL CARE.
WE HOPE TO MAKE YOUR VISIT AS PLEASANT AS POSSIBLE. WE LOOK FORWARD TO SEEING YOU.

PLEASE VISIT OUR WEBSITE AT **www.tbperio.com**