

Request for Patient Information From:

Dr. \_\_\_\_\_ Fax# \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Last Prophy: \_\_\_\_\_

Last Recall Exam: \_\_\_\_\_

Last Perio Charting: \_\_\_\_\_

Perio Therapies: \_\_\_\_\_

Radiographs

Date Taken

Sent

Full Mouth Series: \_\_\_\_\_

YES

NO

Bite Wing Series: \_\_\_\_\_

YES

NO

Periapical: \_\_\_\_\_

YES

NO

Panorex: \_\_\_\_\_

YES

NO

Treatment

Current Treatment Plan Complete:

YES

NO

Treatment Not Complete: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_

Please contact us if you need further information