Chula Vista Periodontics

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Patient's Name:_____

Date: _____/_____/_____

Appt Time/Date: _____

Pt's Phone #: _____

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

PERIODONTAL EVALUATION

- ☐ Crown Lengthening
- ☐ Extraction/Implant
- ☐ Recession
- ☐ Generalized
- ☐ Emergency Tx
- ☐ Bone Graft
- ☐ Localized (Circle tooth/quad)
- ☐ Nightlase Snoring Tx/ Sleep
- ☐ Other_____

OMS EVALUATION

- ☐ Oral Biopsy
- ☐ Extractions/Alveoplasty/Tori Removal
- ☐ 3rd Molar Extractions
- ☐ Full Mouth Extraction
- ☐ Implant/All on X

Referred by: _____ Remarks: _____

Susan T. Nguyen, DDS, MSD
Joyce Turner, DDS, MS
Diplomate of American Board of Periodontology Specialist in Periodontics, Implants, & Laser

Christensen Sicat Hsu, DDS, MSS
Oral & Maxillofacial Surgeon

- ☐ Please send additional referral forms
- ☐ Please send Exam Summary Letter
- ☐ Please call after seeing patient

Thank You!