



PRECISION PERIODONTICS
A N D
IMPLANT DENTISTRY, P.C.

SAROSH F. DASTOOR, D.M.D., M.S.

Introducing _____

Referred by Dr. _____

Office Phone: _____ Date: _____

Please Evaluate Tooth # _____

Generalized Condition

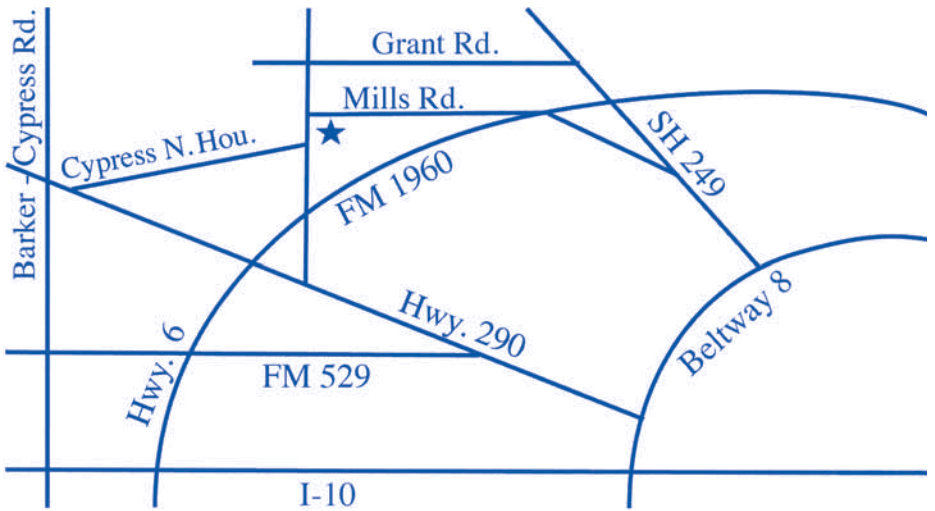
- | | |
|---|---|
| <input type="checkbox"/> Periodontal Disease | <input type="checkbox"/> X-Rays Included |
| <input type="checkbox"/> Crown Lengthening | <input type="checkbox"/> Please take X-Rays and
send copy to my office |
| <input type="checkbox"/> Frenectomy | |
| <input type="checkbox"/> Mucogingival Defect
(Gingival Grafting) | |
| <input type="checkbox"/> Implants: Tooth/ Area: _____ | |
| <input type="checkbox"/> Bone Regeneration | |
| <input type="checkbox"/> Extraction & Socket Preservation | |
| <input type="checkbox"/> Other: _____ | |

Comments: _____

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www.precisionperio.net



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