DENTISTRY AT EAST PIEDMONT
COSMETIC & GENERAL DENTISTRY

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Date: _____

Patient Name: _____

Phone: _____ Email: _____

Referring Doctor: _____

Phone: _____ Email: _____

Reason for visit:

- ❍ Dental Implant Evaluation
- ❍ Cosmetic Evaluation
- ❍ Occlusal Considerations
- ❍ Restore Vertical Dimension
- ❍ Full Mouth Reconstruction
- ❍ Parafunctional Grinding/Clenching
- ❍ Dentures
- ❍ Partial Dentures
- ❍ Crowns
- ❍ Other

Chief Concern: _____

_____

_____

_____

Please call:

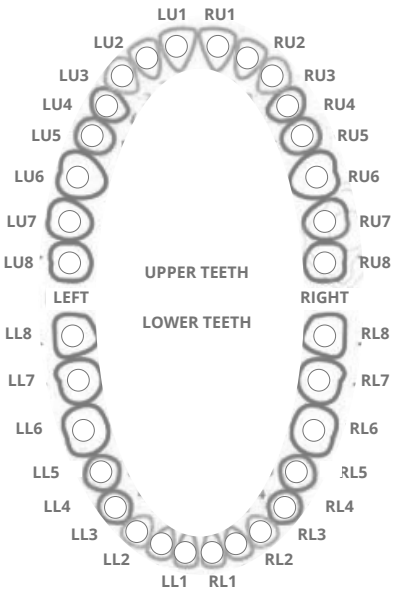
❍ Prior to consultation ❍ After consultation ❍ Letter after exam

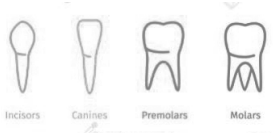
Radiographs:

❍ Enclosed ❍ Sent with patient ❍ Needs radiographs

Oral Surgery Evaluation

Exodontia - *fill in circle(s) indicating extraction(s)*





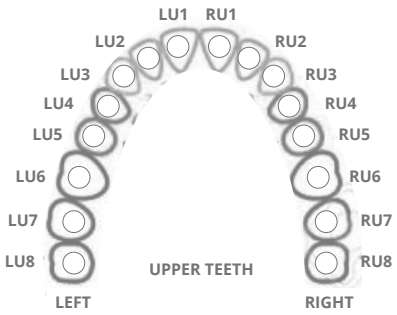
Additional information: _____

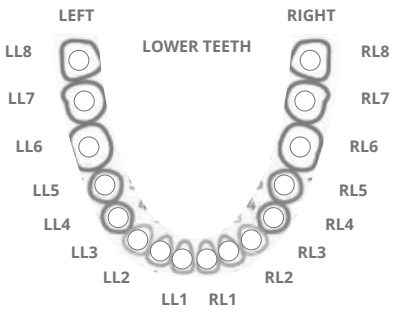
_____

_____

Implant Evaluation

Implant Site - *fill in circle(s) to indicate implant(s)*





Implant Brand: _____

Surgical Template: ❍ Provided ❍ Not Necessary

Bone Grafting / Augmentation: ❍ Yes ❍ No

_____

Soft Tissue Enhancement: ❍ Yes ❍ No

_____

Additional information: _____

_____

_____