LASER PERIODONTICS & IMPLANT DENTISTRY

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Patient Information

Patient's Name:______________________________

Guardian Name (if minor):______________________________

Address: ______________________________

City: ______________________________

State: ____________________ Zip:____________________

Date of Birth: ____________________ Work Phone: ____________________

Cell Phone: ____________________Home Phone: ____________________

Please complete the following:

☐ Comprehensive Examination
☐ Implant Evaluation
☐ Crown Lengthening
☐ Mucogingival Defects
☐ Soft Tissue Grafting
☐ Other

X-Rays Forwarded: ☐ Yes ☐ No

Remarks:______________________________

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Referring Practitioner: ______________________________

Appointment with Dr.: ____________________ ______________________________

Day Month Date

At ____________________ A.M. ____________________ P.M.