DR PHILLIPS
Periodontics & Implants
Christopher S Lee DMD

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Date:_____ Appt Date:_____ Time:_____

Patient Name:_____

Home Phone:_____ Cell Phone:_____

Referred by Dr._____ Office Phone:_____

Please Evaluate For:

- ❑ Generalized Periodontal Disease
- ❑ Localized Periodontal Disease
- ❑ Crown Lengthening
- ❑ Tissue Graft/Recession
- ❑ Gingival Hyperplasia
- ❑ "Gummy Smile"
- ❑ Pathology/Biopsy
- ❑ Implant(s)
- ❑ Ridge Augmentation
- ❑ Sinus Lift
- ❑ Frenectomy / Fiberotomy
- ❑ Unerupted Tooth Exposure
- ❑ Other _____

			a	b	c	d	e	f	g	h	i	j			
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
			t	s	r	q	p	o	n	m	l	k			

Patient Has Received:

- ❑ Prophy Date_____
- ❑ Scaling & Root Planing Date_____
- ❑ Previous Perio Therapy Date_____

Restorative Treatment Plan:

- ❑ Is Planned (Please Comment)
- ❑ Not Indicated
- ❑ Will Be Planned After Perio Eval

Radiographs:

- ❑ FMX
- ❑ Periapical(s)
- ❑ PANO
- ❑ Bitewings

__ With Patient __ Please take during exam
__ E-mailed __ Mailed to the office

Doctor's Comments or other Concerns:

_____

_____

_____

INFORMATION FOR PATIENTS

Welcome to our Periodontal office.

Our office is committed to providing you with the highest quality of care possible. It is our goal to work closely with your Doctor to provide you with the best dental care. Our entire staff looks forward to a pleasant and personal relationship with you.

The **initial visit**, with the exception of certain cases, is for examination / X-rays only. This visit allows us to fully evaluate you, answer any questions and tailor your treatment plan to your specific needs. After the examination, you will be invited back for a consultation.
Please bring all pertinent medical information including names and phone numbers of your physicians and dentists.

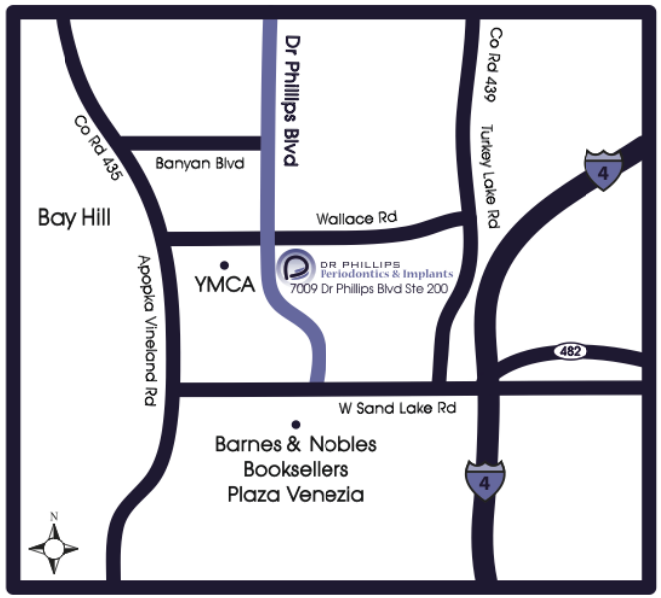
If you are currently taking any medications, please do not stop unless your Doctor has told you to do so prior to your appointment.
Be sure to bring a list of names and doses of all medications that you are taking.
In addition, please bring a list of names and reactions to medications that you are **allergic** to.

Payment is due when services are rendered (Cash, Visa / Master Card).
We will be happy to file with your insurance company for reimbursement.
If you plan to **use insurance**, please bring a copy of your insurance card and / or the company's telephone number. This will allow us to verify your insurance coverage.

Your appointment is reserved **specifically** for you. If by necessity, you must cancel your appointment, please notify us at least 48 hours in advance.

Thank you for choosing us to provide your periodontal / implant care.
We hope to make your visit as pleasant as possible. We look forward to seeing you.

Please visit our website at **www.drphillipsperio.com**



Active Member
American Academy of Periodontology