



RENAISSANCE DENTAL IMPLANT CENTER

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www.renaissancedentalimplant.com

Patient: _____

Patient DOB: _____

Phone number: _____

Date: _____

Will the patient be returning to your office for restoration and maintenance?

- Yes, the patient will receive restoration and implant maintenance at our office. No, please proceed with restoration and implant maintenance at your office.

Check all that may apply:

Implants

- | | |
|--|---|
| <input type="checkbox"/> Extraction with Site Preservation | <input type="checkbox"/> Sinus Augmentation |
| <input type="checkbox"/> Implant Placement | <input type="checkbox"/> Ridge Augmentation |
| <input type="checkbox"/> Overdenture | <input type="checkbox"/> Peri-Implantitis |
| <input type="checkbox"/> Hybrid | <input type="checkbox"/> Implant Removal |
| <input type="checkbox"/> Other _____ | |

Perio

- | | |
|--|--|
| <input type="checkbox"/> Gingival Grafting & Root Coverage | <input type="checkbox"/> Impacted Tooth Exposure |
| <input type="checkbox"/> General Periodontal Evaluation | <input type="checkbox"/> Crown Lengthening |
| <input type="checkbox"/> Limited Periodontal Evaluation | <input type="checkbox"/> Biopsy |
| <input type="checkbox"/> Frenectomy | |
| <input type="checkbox"/> Other _____ | |

Site/Tooth #: _____

For referring doctor use only:

- | | |
|---|---|
| <input type="checkbox"/> Please call before the patient's initial appointment to discuss. | <input type="checkbox"/> I would like to be present for the consult with the patient. |
| <input type="checkbox"/> Please call before consultation and treatment presentation. | <input type="checkbox"/> I am enclosing the patient's radiographs. |
| | <input type="checkbox"/> Models |

Additional comments: _____

Referring doctor: _____

Office name: _____

Phone number: _____

Email: _____