

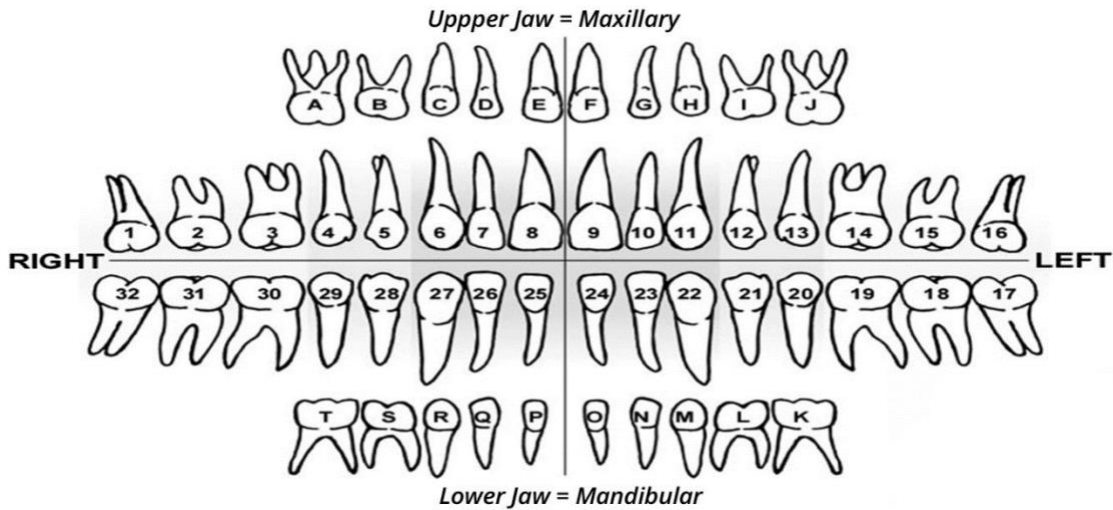
Patient Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_ Patient Date of Birth and Age: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Date of last FMX: \_\_\_\_\_ PAN: \_\_\_\_\_ BWX: \_\_\_\_\_

History and Dates of Periodontal Treatment: \_\_\_\_\_



**PERIODONTAL TREATMENT**

- Periodontal exam
  - Specific location(s): \_\_\_\_\_
- Crown lengthening
- Soft tissue grafting

**IMPLANT AND SURGICAL TREATMENT**

- Implant(s) # \_\_\_\_\_
- Sinus graft
- Ridge augmentation
- Extraction(s) # \_\_\_\_\_
- Bone Grafting
- Exposure of unerupted tooth
- Biopsy
- Tori Removal

**SPECIAL INSTRUCTIONS OR SPECIFICS:**

 **KALAMAZOO  
PERIODONTICS**  
COMAR & LEJA



1900 Whites Rd, Ste 2 Kalamazoo, MI 49008  
Phone. (269) 381-8419  
Email. [office@kzooperio.com](mailto:office@kzooperio.com)  
Website. [kzooperio.com](http://kzooperio.com)

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