



ANCHOR PERIODONTICS

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PATIENT'S NAME: _____

DOB: _____ PHONE: _____ TODAY'S DATE: _____

MEDICAL
ALERTS: _____ INSURANCE: _____

REFERRING DOCTOR: _____

PLEASE CIRCLE TEETH TO BE TREATED

Right	01	02	03	04	05	06	07	08		09	10	11	12	13	14	15	16	Left
	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17	

RADIOGRAPHS

Recent X-Rays / FMX

- ☐ Available — Date Taken: _____
- ☐ Patient Will Bring
- ☐ Mailed to Office
- ☐ Unavailable — Please Take

REASON FOR REFERRAL

- ☐ Periodontitis:
 - ☐ Localized
 - ☐ Generalized
- ☐ Implants: Tooth #'s _____
- ☐ Crown Lengthening: Tooth #'s _____
- ☐ Extractions: Tooth #'s _____
- ☐ Gingival Recession: Tooth #'s _____
- ☐ Oral Pathology — Location: _____

ADDITIONAL COMMENTS: _____

We wanted to sincerely thank you and your patient
for your trust in our office!