John T. Carson, D.D.S., M.S.

PERIODONTICS & IMPLANTS

Diplomate of the American Board of Periodontology

www.carsonperioandimplant.com

INTRODUCING _____

_____

ADDRESS

_____

CITY ZIP

_____

PHONE

❑ Please provide comprehensive periodontal evaluation and treatment as indicated.

❑ Please provide periodontal evaluation limited to area _____

❑ Please evaluate for significance of gingival recession, teeth # _____

❑ Please evaluate for dental implants _____

❑ Please see on EMERGENCY PRIORITY for treatment of teeth # _____

Date of last prophylaxis _____ Root Planing _____

Recent Full Mouth Radiographs are available

❑ Yes ❑ No Dated: _____

Current Radiographs ❑ Sent by mail ❑ Sent with patient ❑ Email

Other/Remarks: _____

_____

_____

_____

❑ Pending restorative treatment plan _____

_____

Date _____ Time _____

Referred by Dr. _____ Date _____

Email: drjtcarson@gmail.com

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(White - Patient Copy, Yellow - Specialist Copy, Pink - File Copy)