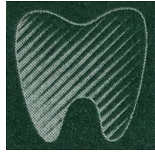

# BUCKHEAD PERIODONTICS

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PHONE: 404-261-9593
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2970 PEACHTREE ROAD NE, SUITE 622
ATLANTA, GA 30305

Date: ________________

Patient: ______________________________________________________________________

Patient Phone: ______________________________ Patient Email: ________________________

Referred by: __________________________________________________________________

## REFERRED FOR:

____ Full periodontal evaluation

____ Laser therapy

____ Gum grafting

____ Crown lengthening

____ Cosmetic gum treatment

____ Gummy smile/lip repositioning

____ Frenectomy/ vestibuloplasty

____ Dental Implants

____ Peri-implantitis/ complications

____ Extraction/site preservation

____ Ridge/sinus augmentation

____ Accelerated orthodontics, PAO

____ Biopsy

____ IV or Oral Sedation

Notes: _______________________________________________________________________

______________________________________________________________________________

Please call:

____ Prior to consultation

____ After consultation

____ Letter following is sufficient

☐ X-Rays will be sent to info@buckheadperiodontics.com

www.buckheadperiodontics.com