



BUCKHEAD PERIODONTICS

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ATLANTA, GA 30305

Date: _____

Patient: _____

Patient Phone: _____ Patient Email: _____

Referred by: _____

REFERRED FOR:

___ Full periodontal evaluation

___ Dental Implants

___ Laser therapy

___ Peri-implantitis/ complications

___ Gum grafting

___ Extraction/site preservation

___ Crown lengthening

___ Ridge/sinus augmentation

___ Cosmetic gum treatment

___ Accelerated orthodontics, PAO

___ Gummy smile/lip repositioning

___ Biopsy

___ Frenectomy/ vestibuloplasty

___ IV or Oral Sedation

Notes: _____

Please call: ___ Prior to consultation ___ Letter following is sufficient

___ After consultation

X-Rays will be sent to info@buckheadperio.com

www.buckheadperiodontics.com