Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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1. How long have you been treating this patient?

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1. What is the frequency of his/her maintenance therapy? Has the patient followed through?

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1. When was the last cleaning visit? Was there more than one?

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1. Tell us about the patient’s desires and concerns (ie. Esthetics, dental phobia, finances, etc.):
2. Have you presented a restorative plan? Please provide details:
3. A current series (within 1 year) O Will be forwarded from our office

of full mouth radiographs is O Please take a new series

required. O Please duplicate my radiographs and return the originals to me

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1. Are there specific areas of the mouth that you would like us to evaluate?
2. Would you like us to contact O Yes

the patient? O No

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