

LASER & IMPLANT

ADVANCED PERIODONTICS

new jersey

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DATE _____

FROM DR. _____

INTRODUCING _____

APPT DATE _____

TIME _____

Please provide 48 hours advanced notice for cancellations. Thank You!

RADIOGRAPHS

- | | |
|--|--|
| <input type="checkbox"/> Please Take New Radiographs | <input type="checkbox"/> Mailed to Office |
| <input type="checkbox"/> Please Take a C.T. Scan | <input type="checkbox"/> Emailed to Office |
| <input type="checkbox"/> Accompanying Patient | |

COMMENTS

PERIODONTAL CONCERNS

- FULL PERIODONTAL EVALUATION _____
- LANAP/PERIODONTAL SURGERY _____
- GINGIVAL RECESSION('S) _____
- BONE/RIDGE AUGMENTATION _____
- SINUS GRAFTING _____
- OTHER _____

DENTAL IMPLANTS

- IMPLANT CONSULT/ BRAND _____
- PERI-IMPLANTITIS _____
- ALL ON X PROCEDURE _____
- COMPUTER GUIDED SURGERY _____
- OTHER _____

COSMETIC CONCERNS

- AESTHETIC CROWN LENGTHENING _____
- GINGIVAL AUGMENTATION _____
- OTHER _____

HYGIENE/PERIODONTAL MAINTENANCE

- PERIODONTIST ALTERNATING REFERRING DENTIST

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SHARING SMILES

*Finding Excellence in Periodontal Care
and Dental Implants*