Thomas Hoover, DDS
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Periodontics • Dental Implants • Cosmetic Dental Surgery

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REFERRED FOR PERIODONTAL/IMPLANT EVALUATION

Date _____

Patient Name _____

I am specially concerned about the following areas:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Reconstruction is contemplated to include the following teeth:

_____

_____

Full mouth x-rays will be sent:

- ❑ By Mail
- ❑ By E-Mail (xray@hooverperio.com)
- ❑ With patient

Maintenance recall appointments following treatment:

- ❑ Alternate between our offices
- ❑ Return patient to my office for all appointments

Dr. _____ Date _____