LIMITLESS PERIODONTICS & IMPLANTS

Ramin Foroughi, DDS

Periodontist & Dental Implant Specialist

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PATIENT NAME _____ **DATE REFERRED** _____

PATIENT PHONE _____ **DATE OF BIRTH** _____

REFERRING DOCTOR _____

REFERRED FOR _____

PROCEDURE(S) REQUESTED

- ☐ Complete Perio Evaluation
- ☐ Implants
- ☐ Extraction / Bone Graft
- ☐ Sinus Augmentation
- ☐ ALL-ON-X
- ☐ Soft Tissue Graft
- ☐ Frenectomy
- ☐ Functional Crown Lengthening
- ☐ Esthetic Crown Lengthening
- ☐ Osseous Surgery (Pocket Reduction)

IMPLANT PREFERENCE

☐ Straumann ☐ Nobel

COMMENTS / AREA OF SPECIAL CONCERN

_____

_____

_____

RADIOGRAPHS

- ☐ Emailed (info@limitlessperiodontics.com)
- ☐ Please take x-rays

TREATMENT DATE

- ☐ Prophylaxis & Gross Scaling — Date of Service: ___/___/___
- ☐ Root Planning — Date of Service: ___/___/___

Do you have restorative plans for this patient? ☐ **YES** ☐ **NO**

If yes, briefly outline your plans: _____

We want to thank you for trusting us with your dental needs.
We look forward to meeting you and making your experience as comfortable as possible.
To help us provide the best care, please bring a list of all medications you are currently taking.

We are located on the 2nd floor, down the hall on the right side.

Meet the Doctor