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COAST PERIODONTICS
& LASER SURGERY

Patient _____ Date _____

Patient's Phone No. _____ Appt. Date _____

Referring Dr. _____ Time _____

- ❑ Sending Radiographs/FMX
- ❑ Radiographs Needed
- ❑ Premed Needed
- ❑ Other Medical Concerns _____

PURPOSE OF REFERRAL:

- ❑ **Call Before Consultation**
- ❑ **Call After Consultation**
- ❑ Bacterial Analysis
- ❑ Periodontal Maintenance Recalls
- ❑ Occlusal Analysis

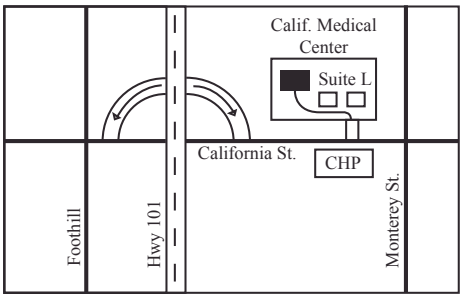
Specific area of concern _____

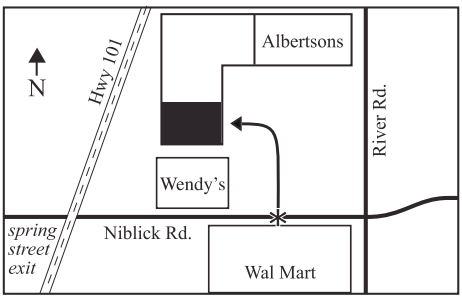
LASER PROCEDURES:

- ❑ Laser Assisted Pocket Reduction
- ❑ Laser Frenectomy
- ❑ Biopsy
- ❑ Gingival Grafting
- ❑ Bone Grafting
- ❑ Functional/Esthetic Crown Lengthening

Additional Information _____

Prior to your visit, we offer our Website at www.coastperiodontics.com for Forms, Frequently Asked Questions and other informative facts.





~ We appreciate your confidence ~