PERIODONTAL
ASSOCIATES
OF SOUTH BEND

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Date ______________

Introducing ____

Patient Phone # ____

Referred by Dr. ____

- ❑ Comprehensive Periodontal Examination
- ❑ Limited Examination: Area ______________________________
  - ❑ Crown Lengthening: Tooth ____________________________
  - ❑ Bone Loss: Area ______________________________________
  - ❑ Frenum: Area ____
  - ❑ Gingival: Area _______________________________________
- ❑ Implant Examination: Area ______________________________
- ❑ Other ____

Radiographs:

- ❑ Please take full mouth series
- ❑ Please take an x-ray of area
- ❑ We are sending these x-rays: _____________________________

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Comments: ____

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Appointment Time and Date: ______________________________

Please give 2 working days' notice if rescheduling is necessary.

TO EXPEDITE YOUR REGISTRATION, PLEASE VISIT OUR WEBSITE, PERIOASB.COM
TO SUBMIT YOUR PATIENT REGISTRATION FORMS PRIOR TO YOUR VISIT.

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