ESSENTIAL

ENDODONTICS | PERIODONTICS & IMPLANTS

Arushi Kakar, B.D.S., M.D.S., M.S.D.

REFER TO:

Please select an office below.

☐ **BURLESON**
101 NW Renfro St., Ste. 102
Burleson, TX 76028
O: 817.295.1444
F: 817.295.1445
burleson@essentialendotx.com

☐ **COLLEYVILLE**
5209 Heritage Ave. Ste. 400
Colleyville, TX 76034
O: 817-571-1700
F: 817-571-1702
colleyville@essentialendotx.com

PATIENT INFORMATION:

Please fill out each line below.

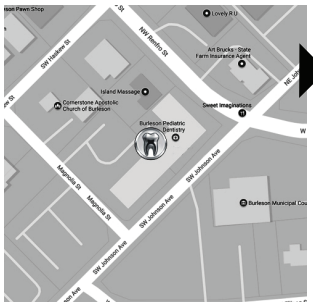
Legal Name _____ Phone _____ DOB _____

Referred By _____ Doctor's Signature _____ Doctor's Phone _____

DATE OF REFERRAL:

REFERRED FOR:

- ☐ Comprehensive Periodontal Examination (periodontal disease)
- ☐ Limited Examination:
  - ☐ Extraction and ridge preservation - Tooth #____
  - ☐ Crown lengthening - Tooth #____
  - ☐ Bone loss - Area____
  - ☐ Gingival recession - Tooth #____
  - ☐ Frenectomy
  - ☐ Implant (single, "all on 4"/ overdenture) - Tooth #____
  - ☐ Periimplantitis - Implant #____
  - ☐ Mucocutaneous lesions - Area____
  - ☐ Sinus augmentation
  - ☐ Other



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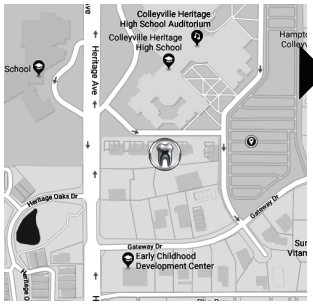

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RADIOGRAPHS:

Please submit radiographs to perio@essentialendotx.com.
Please check box for radiographs that have been submitted:

- ☐ PA tooth # _____
- ☐ PANO
- ☐ FMX

COMMENTS: