

ESSENTIAL



REFER TO

Reet Sandhu, D.D.S., M.S. PERIODONTIST

BURLESON

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Burleson, TX 76028
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COLLEVILLE

5209 Heritage Ave., Ste. 400
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FORT WORTH

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Fort Worth, TX 76107
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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

RADIOGRAPHS

Please submit radiographs to perio@essentialendotx.com.

Please check box for radiographs that have been submitted:

- PA tooth # _____
- PANO
- FMX

Temp Implant by Specialist:

If Extraction is needed, Refer Back Perform Extraction

COMMENTS

