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NORTHEAST GEORGIA PERIODONTICS
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REFERRING DENTIST:

PATIENT INFO:

NAME _____

PHONE _____

LEVEL OF TREATMENT DESIRED:

- Evaluate & Treat Comprehensively
- Evaluate & Treat Specified Areas Only
- Evaluate & Call to Review Treatment Plan

COMMENTS:

TREATMENT NEEDED:

PERIODONTAL CARE

- Full Mouth Periodontal Treatment
- Scaling and Root Planing
- Soft Tissue Grafts
- Osseous Surgery
- Tori Removal
- Gingivectomy
- Frenectomy
- Crown Lengthening

TMJ

- Evaluation and TMJ Therapy
- Splint Fabrication

IMPLANTS

- Implant Evaluation
- Location: _____

EXTRACTIONS

- Extraction # _____
- Extraction & Bone Graft # _____

GRAFTS

- Soft Tissue Graft
- Bone Graft

CROWN LENGTHENING

- Crown lengthening

ORTHODONTIC

- Tooth Exposure
- Frenectomy
- Graft
- Fiberotomy
- Gingivectomy

COSMETIC TREATMENT

- Root Coverage Grafting
- Gingivectomy
- Crown Lengthening

BIOPSY

- Biopsy: Location _____

CAT SCAN

- Full Mouth / Head CT Scan