Please fax a copy of this referral to **(910) 577-1078** or email **office@implantperiohealth.com**

JOSE I. ARAUZ, D.M.D.
PRACTICE LIMITED TO PERIODONTICS AND DENTAL IMPLANTS
DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY

OFFICE: (910) 577-1315
FAX: (910) 577-1078
EMAIL: office@implantperiohealth.com

THIS IS TO INTRODUCE _____ APPOINTMENT DATE _____ TIME _____

❑ Comprehensive periodontal evaluation ❑ Recession ❑ Biopsy ❑ Crown Lengthening ❑ Periodontal Therapy ❑ Implant Therapy

❑ Implant tooth # _____

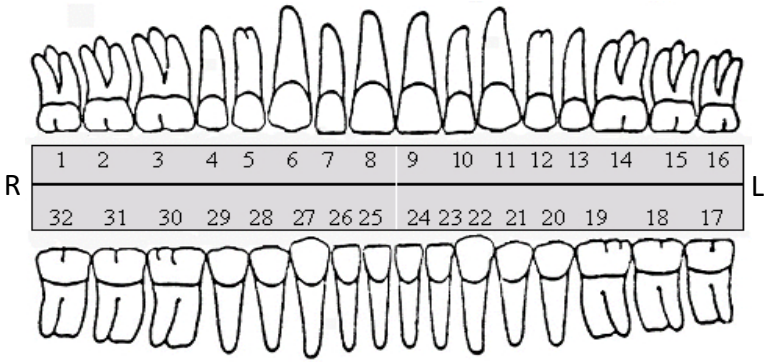
❑ Extraction tooth # _____

❑ Periodontal evaluation ***performed***: isolated area(s) of concern are

❑ Periodontal evaluation ***needed***: isolated area(s) of concern are

_____

_____



RADIOGRAPHS

❑ Please take ❑ Will send: ❑**Full** ❑**Modified** ❑ Prior X-rays available

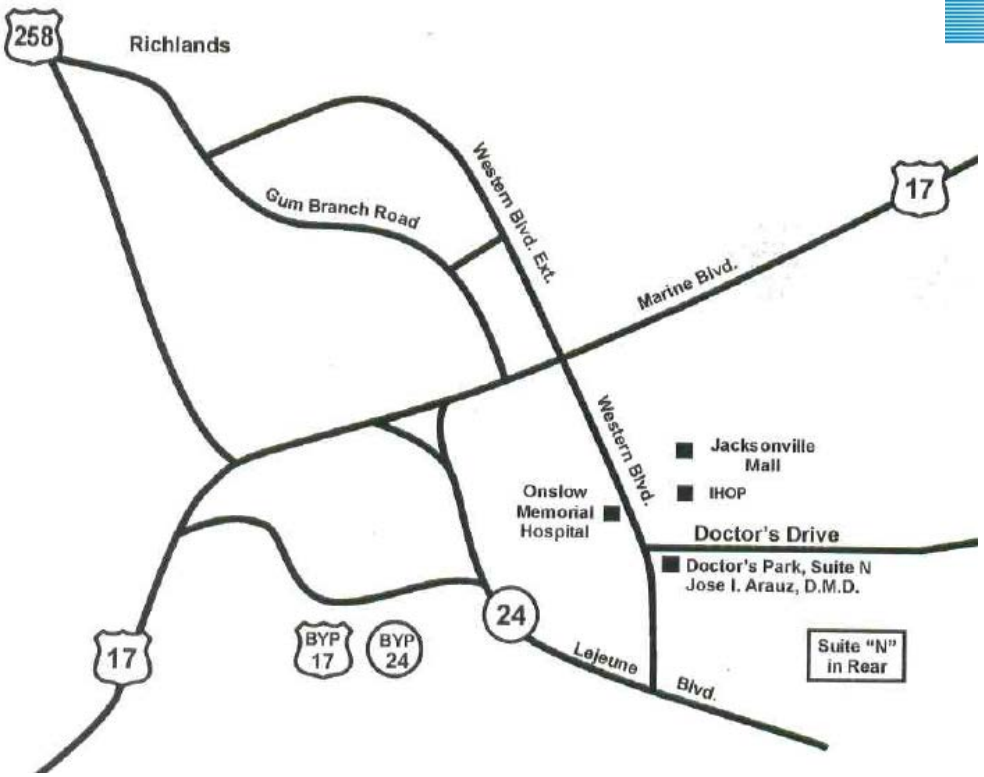
RESTORATIVE TREATMENT

❑ Completed ❑ Established ❑ Pending periodontal findings

COMMENTS _____

_____

DATE_____ REFERRING DR._____PHONE_____EMAIL_____



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In order to serve you better, please arrive 15 minutes before your scheduled appointment time with the following items:

- Dental Insurance Card(s)
- Written instructions from your doctor (if not included on this form)

Se habla Español

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