



PRECISION PERIODONTICS & DENTAL IMPLANTS

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Diplomates of the American Board of Periodontology

Introducing: _____ **Date:** _____

Phone / Email: _____

Referred by: _____

Phone / Email: _____

Circle areas of concern

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Reason for Referral

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Periodontal Disease | <input type="checkbox"/> Implants | <input type="checkbox"/> Exposure |
| <input type="checkbox"/> Gingival Recession | <input type="checkbox"/> Sinus Graft | <input type="checkbox"/> Extraction |
| <input type="checkbox"/> Crown Lengthening | <input type="checkbox"/> Biopsy | <input type="checkbox"/> Frenectomy |
| <input type="checkbox"/> Laser Treatment /
LANAP® | <input type="checkbox"/> Pinhole Surgical
Technique® | <input type="checkbox"/> Other _____ |

Comments: _____

Radiographs*: _____ Office Sending _____ Patient Bringing _____ Take as Needed

*Please email digital versions to: support@perioprecision.com

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