POTOMAC
PERIODONTICS and IMPLANT
P.E.A.R
Perfect Evolution in Aesthetics and Regeneration

Shahram Vaziri, DDS, Ph.D

Referring Doctor:_____ Date:_____

Patient information:

Name:_____

DOB:_____ Phone:_____

Please call me regarding this patient:

Before evaluation___ After your evaluation___

No need to call; Written report will suffice___

Reason for referral:

(See back for checklist or write below)

_____

_____

_____

_____

_____

_____

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Potomacperioimplant.com

Reason for referral:

(Check all that apply)

Dental Implant Evaluation:

Site #(s) _____ __Full Arch __Maxillary __Mandibular

Please describe your implant system preference:

_____

Existing implant evaluation: #(s)_____

Peri-Implantitis___ Bone loss___

Periodontal Evaluation:

Full mouth:____ Limited, Site: #(s)_____

Periodontal Maintenance__

Crown Lengthening__

Laser Assisted Periodontal Therapy__

Pocket Reduction Surgery__

Soft Tissue Evaluation:

Recession:___

Lack of keratinized tissue/Attached gingiva #(s):_____

Vestibular evaluation:____

Esthetic Evaluation:

Gummy Smile:___ Low Lip Line (Sagging upper lip):___

Papillary loss:___

Other: _____

__Extraction & Ridge Preservation

__Immediate Implant Placement

__Sinus Life (Internal / Lateral)

__Full Arch Solutions / Overedentures

__IV Therapy (Antibiotic, Analgesic, Anti-inflammatory, Sedative)