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Mylinh Duong, DDS, MS

Practice Limited to Implants and Periodontics

Patient: _____ Date: _____
Telephone: _____
Referred by: _____

PLEASE BRING THIS FORM TO YOUR APPOINTMENT

This patient is being referred for evaluation of the following symptoms/conditions:

- | | |
|--|--|
| <input type="checkbox"/> Gingival Recession/Grafting | <input type="checkbox"/> Biopsy/ Oral Lesion |
| <input type="checkbox"/> Comprehensive Periodontal Evaluation | <input type="checkbox"/> Frenectomy |
| <input type="checkbox"/> Crown Lengthening for Restoration | |
| <input type="checkbox"/> Crown Lengthening for Aesthetics | |
| <input type="checkbox"/> Furcation Involvement/ Guided Tissue Regeneration | |
| <input type="checkbox"/> Implant Consultation | |
| <input type="checkbox"/> Extraction and Immediate Implant | |
| <input type="checkbox"/> Extraction and Ridge Preservation for Delayed Implant | |
| <input type="checkbox"/> Sinus Lift | |
| <input type="checkbox"/> Ridge Augmentation | |
| <input type="checkbox"/> Isolated Periodontal Evaluation | |
| <input type="checkbox"/> Orthodontic Co-therapy | |
| <input type="checkbox"/> Tooth Exposure | |
| <input type="checkbox"/> Other: _____ | |

Comments: _____

- | | |
|---|--|
| <input type="checkbox"/> Please call before proceeding with treatment | <input type="checkbox"/> I have included radiographs for your evaluation |
|---|--|

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