S.C. WALLACE, D.D.S., M.H.S.

Practice Limited to Periodontics
Implant Surgery • Oral Plastic Surgery

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www.drstevewallace.com

Date: ____________________ Patient Name: __________________________________ DOB: ________________

Home #: _______________________ Work #: _______________________ Cell #: _________________________

Email Address: ____

Dental Insurance Coverage? ❑ Yes ❑ No

Referring Dentist: __________________________________ Appointment Date & Time: ____________________

REASON FOR REFERRAL

❑ Complete Periodontal Evaluation

❑ Limited Evaluation: ______________________________

❑ Crown Lengthening: # __________________________

❑ Soft Tissure Graft: # ___________________________

❑ Expose & Bond: # ______________________________

❑ Implant Placement: ________________________

❑ Ridge Augmentation: _______________________

❑ Peri-Implantitis: ____________________________

❑ Sinus Graft: _______________________________

❑ Biopsy: ___________________________________

Perio Treatment Completed In Your Office:

❑ Plaque Control Instruction

❑ Root Planning-Date: _________________________

❑ Prophylaxis / Gross Scale / Perio Recare

X-rays & Full Mouth Probing:

❑ Sent By Mail ❑ Sent By Patient

❑ Sent By Email ❑ Please Take

❑ Type & Date ________________________________

Restorative Needs: ____

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NOTES: ____

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OFFICE LOCATION