Athens Perio
• Periodontics • Dental Implants •
Fax: 706-543-9801 GA WATS: 1-800-822-4632

Date: _____ **Referring Dentist:** _____

Referring to: ☐ **F. Neal Pylant, D.M.D.** ☐ **Scott Lowry, D.M.D.**

Introducing for periodontal consultation:

_____

Patient

- ☐ **General full mouth exam** _____
- ☐ **Local area** _____
- ☐ **Abscess / Acute problem** _____
- ☐ **Mucogingival problem** _____
- ☐ **Implant (PAN needed)** _____
- ☐ **Esthetic procedures** _____
- ☐ **Other:** _____

_____

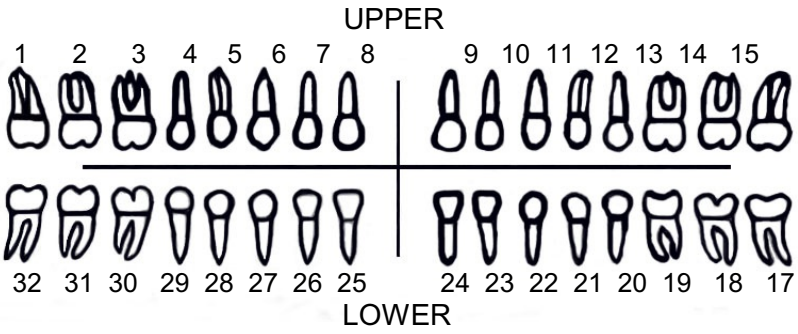
Does the patient need to premedicate: ☐ **No** ☐ **Yes**

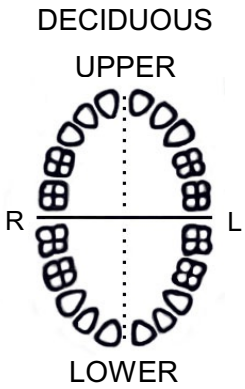
Initial contact:

- ☐ **Patient will call us**
- ☐ **We will call patient:** **Work #:** _____
  Home #: _____
  Cell #: _____

Recent x-rays:

- ☐ **Needs FMX**
- ☐ **Will hand carry**
- ☐ **Will be mailed**
- ☐ **Will be emailed**





Comments: _____

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