BIRD PERIODONTICS
ALBERTO M. BIRD DMD MSCD
Periodontics and Dental Implants

Date_____

Patient's Name: _____

Patient's Phone Number: _____

Referring Doctor: _____

( ) FULL MOUTH EXAM OR ( ) ISOLATED AREA: _____

_____

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

[ ] Osseous Surgery [ ] Guided Tissue Regeneration

[ ] Crown Lengthening [ ] Soft Tissue Grafts

[ ] Implants [ ] Extraction with Bone Graft

[ ] Other: _____

Additional Remarks:

_____

_____

_____

_____

Dentist Signature_____

[ ] x-rays enclosed or Email to: dr@periobird.com

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