AUGUSTO ARAUJO, D.M.D., P.A.

Practice Limited to Periodontics & Implants

Patient: _____ Date: _____

Referred by Dr. _____ Tel #: _____

Reason for Referral:

- ☐ Complete Periodontal Evaluation _____
- ☐ Isolated Area To Be Checked _____
- ☐ Clinical Crown Lengthening _____
- ☐ Gingival Recession/Mucogingival Concern _____
- ☐ Occlusal Habit/Dysfunction _____
- ☐ Implant Evaluation _____
- ☐ Ridge Augmentation _____
- ☐ Other _____

Radiographs

- ☐ Radiographs sent with patient
- ☐ FMX or necessary x-rays to be mailed before appointment
- ☐ Please take necessary x-rays or FMX and send me a set

Comments _____

_____

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