HOLLING AND RIGGS
IMPLANT DENTISTRY \ PERIODONTICS
Superior Care To Preserve And Enhance Your Natural Smile

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Patient's Name: _____ ***Referring Doctor:*** _____
Appointment Date & Time: _____ ***Today's Date:*** _____
Reason for Referral and Concern:

( ) Complete Periodontal Evaluation: _____
_____
( ) Implant evaluation: tooth no(s), or area(s), preferred system: _____
_____
( ) Recession/Inadequate attached gingiva/soft tissue grafting: tooth no(s) _____
_____
( ) Functional crown lengthening: tooth no(s): _____
_____
( ) Esthetic crown lengthening/gingival contouring: tooth no(s): _____
_____
( ) Ridge augmentation to enhance esthetics in pontic area(s): _____
_____
( ) Other: _____
_____

Tentative Restorative Treatment Plan:

( ) Restorative consultation desired after periodontal consultation:
( ) Restorative already completed:
( ) Minor restorations only:
( ) Primary Restorative Treatment Plan: _____
_____
_____

Secondary Restorative Treatment Plan: _____
_____
_____

Doctor's Concerns:

_____
_____
_____

Patient's Concerns/Fears/Motivators:

_____
_____
_____

X-Rays: Please email to hollingperiodontics@hotmail.com

( ) Full mouth series taken within last year enclosed
( ) Take necessary x-rays and send duplicate set for my records
( ) Bitewings enclosed
( ) Panoramic image enclosed or emailed