Mark T. Lavin
PERIODONTICS & DENTAL IMPLANTS
3400 E. 26th Street | Sioux Falls, SD 57103
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TODAY'S DATE: _____ PATIENT'S NAME: _____

PATIENT'S PHONE: _____ APPOINTMENT: _____
DAY DATE TIME

REFERRED BY DR. _____ OFFICE PHONE: _____

[PLEASE CIRCLE TEETH OR SITE TO BE EVALUATED OR TREATED]

UR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	UL
LR	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LL

OTHER: _____

PERIODONTIC CONSIDERATIONS

❑ Patient needs to be pre-medicated ❑ Patient has pain, swelling, sensitivity
❑ Other (please specify)_____

TREATMENT REQUESTED

❑ Periodontal/SCRP evaluation ❑ Crown lengthening
❑ Implant evaluation ❑ Gingival recession
❑ Limited evaluation (please specify)_____

RADIOGRAPHS

❑ Will need to be taken
❑ Have been e-mailed to contact.us@marktlavindds.com

ADDITIONAL COMMENTS

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