Patient _____

Home # _____ Cell # _____

Preferred # _____

Appt. Date _____ Time _____

From Dr. _____ Date _____

- ☐ Comprehensive exam and treatment
- ☐ Implant examination
- ☐ Laser Evaluation
- ☐ Please do a limited examination
- ☐ Please call me
- ☐ FMX Forwarded
- ☐ FMX Unavailable - Please take
- ☐ Prophy Date _____
- ☐ Root Planing Date(s) _____
- ☐ Restorative plans, special concerns, etc.

_____

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KENNETH R. LEVINE D.D.S.
PERIODONTIST

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AREA OF CONCERN

- ☐ Bleeding _____
- ☐ Mobility/Occlusion _____
- ☐ Root Coverage _____
- ☐ Mucogingival Problem _____
- ☐ Bone Loss and Pockets _____
- ☐ Crown Lengthening _____
- ☐ Questionable Teeth _____

Recommended Post TX Maintenance

- ☐ All at my Office ☐ Alternate
- ☐ All at Dr. Levine's Office

Please Fax to 954-722-1434