Braden C. Seamons, D.D.S. Diplomate of the American Board of Periodontology

Laser Therapy • Implants

Introducing Patient: _____ Date: _____

Referring Dentist: _____

My Patient is: ☐ New to my practice

☐ My patient for _____year(s)

Dental Insurance: _____ Group# _____

My Patient Requires:

☐ A complete periodontal examination to include:

__Periodontal treatment recommendations

__Restorative/Prosthetic recommendations

☐ A limited periodontal examination (circle area/teeth)

Right 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 **Left**

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

☐ Crown lengthening tooth/teeth #_____

☐ Implant Evaluation tooth/teeth #_____

☐ Other (explain in Comments)

Radiographs:

Recent X-rays are available: Circle Type: FMX BWX PA

☐Date Mailed ___/___/___

☐Patient given x-rays to bring

☐Please take necessary radiographs

Appointment:

☐Appointment scheduled: Date:____/____/____ Time:_____

☐Patient requests office to call for scheduling: Phone:_____

Comments: _____

_____

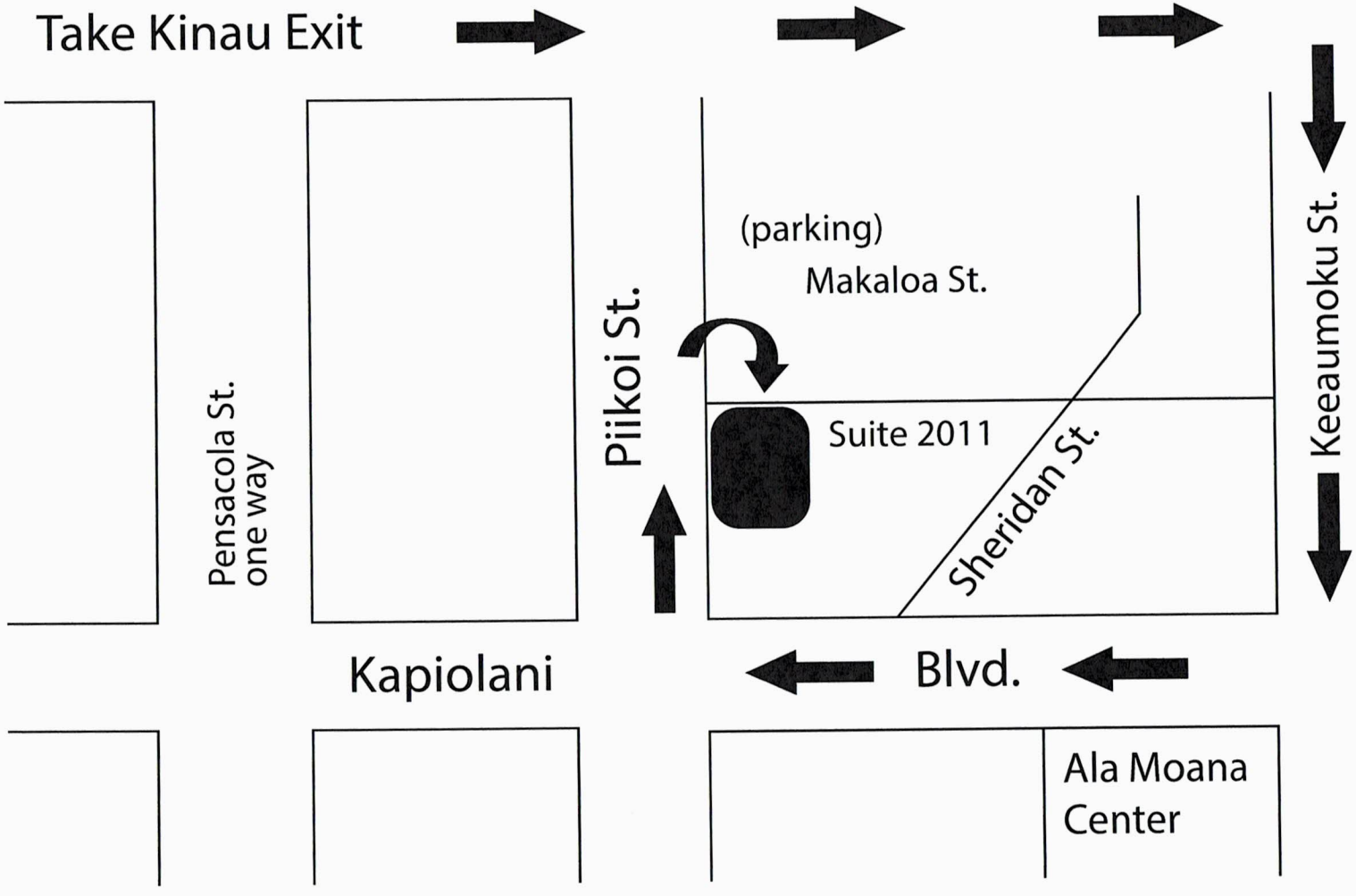
_____

_____

☐Please send additional referral forms:

HONOLULU OFFICE: 615 PIIKO'I STREET STE. 2011 HONOLULU, HI 96814

PHONE: (808) 596-7788 FAX: (808) 591-0241


Take Kinau Exit
Pensacola St.
one way
Kapiolani
Blvd.
Piikoi St.
(parking)
Makaloa St.
Suite 2011
Sheridan St.
Keeaumoku St.
Ala Moana
Center