

17881 Beach Blvd
 Huntington Beach, CA 92647
 Tel. 714-847-3513
 Fax. 714-375-2199
 www.ocspecialtyendo.com



Date ___/___/___ Introducing _____ Referred by Dr. _____

Please circle tooth or teeth for Periodontics consideration

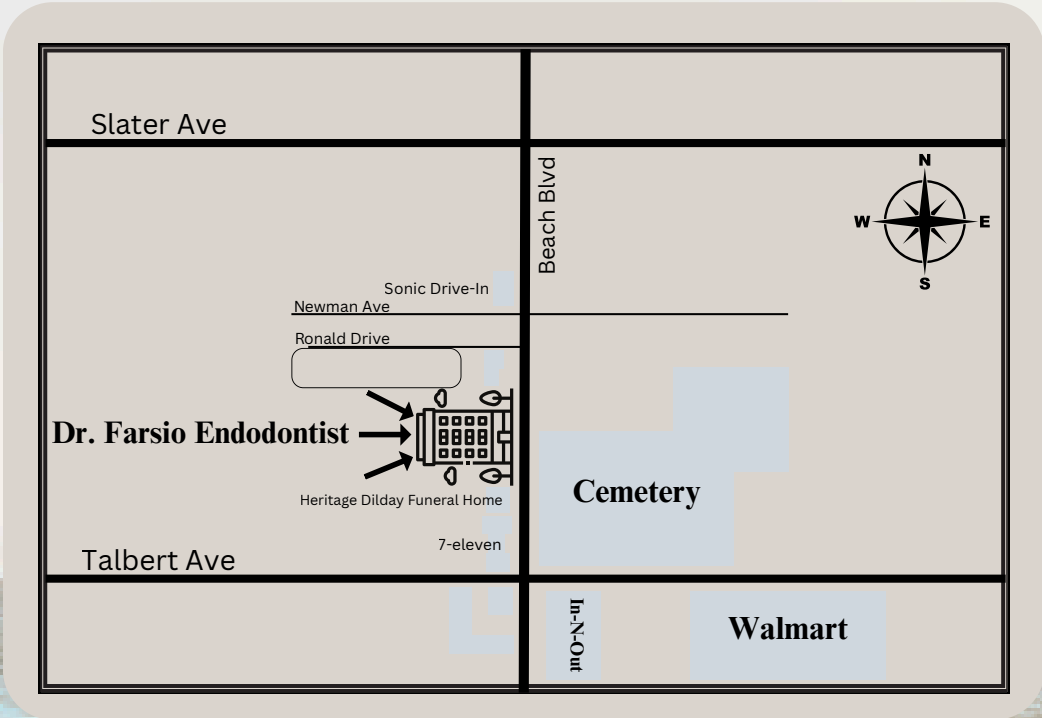
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

- Full Mouth Periodontal Exam _____
- Limited Periodontal Exam _____
- Periodontal Pockets
- Dental Implants
- Extraction/ Socket Preservation
- Ridge Augmentation
- Soft Tissue Lift
- Sinus Lift
- Osseous Surgery/Bone Graft
- Crown Lengthening
- All 4 or 6
- Failing Implant Rescue
- Biopsy (Hard/Soft Tissue)
- Other _____
- Analgesic/Antibiotic Prescribed _____

Appointment Scheduled For

Date _____ Time _____

Please bring this referral form with you to your appointment.



O.C.SPECIALTIES
PERIODONTICS
 DENTAL GROUP



oc_specialtydental



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