DR. M. VIRGINIA KIRKLAND
DR. AMY PADHIAR

NORTH POINT
PERIODONTICS
DENTAL IMPLANTS

Date of referral: _____/_____/_____
(Month) (Day) (Year)

Referring Doctor: _____ **General Practitioner:** _____
(If different from referral doctor)

Dr. Office Phone Number: _____

Introducing: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. _____
(Last) (First) (M.I.) (Preferred Name)

Home#: _____ **Work#:** _____ **Cell#:** _____

Please Evaluate:

- ☐ Periodontal/Peri-Implantitis Condition
- ☐ Osseointegrated Implant Therapy
- ☐ Crown Lengthening, Tooth # _____
- ☐ Cosmetic Gingival Recontouring
- ☐ Biopsy
- ☐ Tissue Grafting
- ☐ Recession
- ☐ Periapical Abscess
- ☐ Frenulectomy and Fiberotomy
- ☐ Periodontal Maintenance Care
- ☐ Impacted Tooth Exposure
- ☐ Endodontic/Periapical Surgery
- ☐ Laser Periodontal Therapy

☐ Special Problem Areas Limited To:

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

☐ Other _____

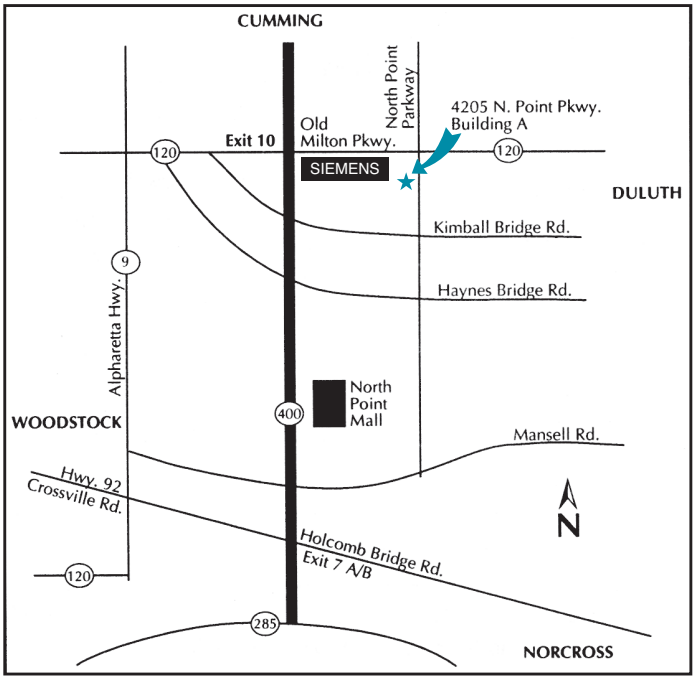
☐ PLEASE CONTACT PATIENT TO SCHEDULE AN EXAMINATION APPOINTMENT.

Appointment:* Date:_____/_____/_____ Time: _____A.M. _____P.M.
(Month) (Day) (Year)

*If unable to honor appointment please give courtesy of 48 hours notice: (770) 740-0442
If you have dental insurance, be sure to bring your insurance card with you.

OUR OFFICE IS
LOCATED AT:
4205 North Point Pkwy.
Building A
Alpharetta, GA 30022
(770) 740-0442

Please visit our
website at
www.npperioimplants.com



PLEASE GIVE THIS COPY TO PATIENT