

# Oklahoma Center for Implants & Periodontics

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referred by Dr. \_\_\_\_\_ Phone: \_\_\_\_\_

## Reason for Referral:

- Complete Periodontal Evaluation: \_\_\_\_\_
- Soft Tissue Grafting: \_\_\_\_\_
- Periodontal Abscess: \_\_\_\_\_
- Implant Consult - Tooth #(s): \_\_\_\_\_
- Clinical Crown Lengthening: \_\_\_\_\_
- Frenectomy: \_\_\_\_\_
- Other: \_\_\_\_\_
- Second Opinion only: \_\_\_\_\_

Previous Periodontal Treatments: \_\_\_\_\_

Tentative Restorative Plans: \_\_\_\_\_

## Please Contact Me:

- Prior to exam
- Patient in Chair
- After exam
- By Phone
- By Mail
- By Fax

## Recent Radiographs:

- Patient has radiographs
- Sending to the Periodontist
- Please take appropriate x-rays

REMARKS: \_\_\_\_\_

*Save time and fill out your new patient paperwork, now available on our website.*



**Appointment Date/Time:**

\_\_\_\_\_