Brandon West, D.D.S., M.S.
Karl Zeren, D.D.S.
Diplomates of the American Board of Periodontology
Practice Limited to Periodontics & Dental Implant Surgery
9515 Deereco Rd., Suite #308, Timonium, MD 21093
***Office*: (410) 252-0871**
***Email*: admin@westperiodds.com**

Patient Name:_____
Patient Phone Number:_____
Referring Doctor:_____
Doctor Phone Number and Email:_____ ☐ ☐
***Please email or mail us any previous radiographs related to the case* Is there a previous CBCT? YES NO**

Referral for Periodontal Therapy (Please check/circle all that apply):

- **Comprehensive Periodontal Exam**
  - ☐ Pocket Reduction Surgery – Quads: ○UR ○UL ○LL ○LR
  - ☐ Guided Tissue Regeneration - Teeth #_____
  - ☐ Laser Treatment
- **Soft Tissue Grafting for Recession Repair Teeth #_____**
- **Extraction(s)#_____**
- **Dental Implant Site(s)#_____**
  - ☐ Surgical Extraction
  - ☐ Bone Grafting + Resorbable Barrier (Alveolar Ridge Preservation)
  - ☐ Immediate Provisional Crown with Immediate Implant
  - ☐ Maxillary Sinus Augmentation
  - ☐ Guided Bone Regeneration (Horizontal/Vertical Ridge Deficiency)
- **Final Restorative Plan**:
  - ☐ Single Crown
  - ☐ Bridge(s)
  - ☐ Overdenture
  - ☐ Full Arch - Hybrid Fixed
- **Pre-Prosthetic Preparation Site(s)#_____**
  - ☐ Crown Lengthening
  - ☐ Alveoloplasty
  - ☐ Soft Tissue Sculpting/Bulking Under Pontic(s)
- **Biopsy – Oral Pathology Site(s)#_____**
- **Impacted Tooth Uncovering for Orthodontic Treatment Site(s)#_____**
- **Peri-implantitis – Implant(s)#_____**
  - ☐ Pocket Elimination
  - ☐ Implant Removal

***Comments*:**

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