Date_____

Douglas A. Heller, DMD
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Jenna C. Hyer, DDS, MS

Colorado's Premier Provider of Dental Implants & Periodontics

Introducing _____ Telephone _____

Address _____
Street City Zip

Dr. _____

Telephone _____

❑ Appointment Date_____

❑ Please call patient to schedule appointment ❑ Patient will call to schedule

Is antibiotic premedication needed? ❑ Yes ❑ No

❑ Implant Evaluation_____

❑ Complete Perio. Exam_____

❑ Recession _____

❑ Crown Lengthening _____

❑ Other _____

Please indicate particular areas of concern, restoration plan, implant or esthetic areas, etc.

_____

_____

_____

_____

_____

Radiographs: ❑ Please take & send copy

Films Available: ❑ Full mouth ❑ Limited ❑ Panoramic

Being Sent: ❑ By Email ❑ By mail ❑ With patient

Please call me: ❑ Before ❑ After seeing patient

Periodontal Associates
The Dental Implant Team

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Please detach and give top copy to patient.
Please fax card to our office or fold for mailing.

email: appointments@periodontalhealth.com