LOWELL STREET
Dental Implant & Surgical Center

GREGGORY S. WILDE, DDS
www.LowellStreetCenter.com
Email: Info@LowellStreetCenter.com
P (360) 692-0300 | F (360) 698-2988

Date: _____

Referring Doctor: _____ Phone: _____

Patient's Name: _____ DOB: _____

Phone (Cell): _____ Phone (Home): _____

Patient's Email: _____

☐ Crown Lengthening	☐ Co-Diagnosis	☐ Periodontal Disease
☐ Gingival Graft	☐ Pocket Reduction	☐ Wilckodontics
☐ Frenectomy	☐ Oral Pathology	☐ Cosmetic Gingival Contouring
☐ Ridge Augmentation	☐ Bone Graft	☐ General Extraction / Wisdom Teeth
☐ Implants	☐ Impacted Tooth Exposure	☐ Temporary Anchorage Device (TAD)
☐ IV Sedation	☐ Perioscope	☐ 3-D Dental Imaging

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

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

☐ Comprehensive Periodontal Examination: ☐ Limited Periodontal Examination:

Location and nature of problem: _____

_____

_____

Diagnostic Documentation:	***Desired Referral Outcome:***
☐ Full-mouth radiograph (dated) enclosed	☐ Diagnosis and treatment at Lowell Street Center
☐ Periodontal Charting (dated) enclosed	☐ Diagnosis and alternating office treatment
☐ Lowell Center will take new x-rays & send copy	☐ Diagnosis only
	☐ Call referring doctor prior to treatment

☐ Extraction/Bone Graft – Teeth #: _____

In preparation for: ☐ Implant ☐ Bridge ☐ Denture

☐ Implant Evaluation

Area to be restored with implants: _____

Types of restorations planned: _____

☐ Has patient been seen in our office before: ☐ Yes ☐ No

☐ Special Comments: _____

Silverdale Office Map