



BRIER CREEK
 IMPLANTS & PERIODONTICS
 ALICE WU, D.D.S., M.S.



Referring Doctor: _____ Date: _____

Patient Name: _____ Male: _____ Female: _____

Phone: _____ Email: _____

Appointment Date and Time: _____

Does Patient Require Antibiotics Before Dental Appointment: Yes _____ No _____

Radiographs:

Take New _____ Accompanying Patient _____ Emailed to Your Office _____

PERIODONTAL THERAPY:

Full Periodontal Evaluation _____

Local Periodontal Evaluation _____

Laser Periodontal Therapy / LANAP _____

Crown Lengthening _____ Gingival Graft _____

Biopsy _____ Other _____

IMPLANT THERAPY:

Implant _____

Ridge Augmentation _____

Sinus Lift _____

Extraction _____

Socket Preservation _____

Other _____

ADJUNCTIVE THERAPY:

Frenectomy _____

Tooth Exposure _____

IV Conscious Sedation _____

Other _____

RESTORATIVE PLAN:

COMMENTS:
