



# BEN CHOI

PERIODONTICS & IMPLANTS

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Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient phone: \_\_\_\_\_

Referring Doctor(s): \_\_\_\_\_ Office phone: \_\_\_\_\_

Please email most current x-rays to info@benchoiperio.com

## COMMENTS:

**Reason for Referral** \_\_\_\_\_

\_\_\_\_\_ Comprehensive Periodontal Exam

\_\_\_\_\_ Extraction

\_\_\_\_\_ Radiographic Bone Loss

\_\_\_\_\_ All-on-X

\_\_\_\_\_ Dental Implants

\_\_\_\_\_ LANAP (laser dentistry)

\_\_\_\_\_ Peri-Implantitis

\_\_\_\_\_ Biopsy

\_\_\_\_\_ Gum Recession / Gum Graft

\_\_\_\_\_ Tori Removal

\_\_\_\_\_ Frenectomy

\_\_\_\_\_ Bone Graft

\_\_\_\_\_ Crown Lengthening

\_\_\_\_\_ Wisdom Teeth Removal

\_\_\_\_\_ Sinus Augmentation

\_\_\_\_\_ Orthodontics

\_\_\_\_\_ Canine Exposure