

Amir D. Hosseini, D.D.S.
PERIODONTAL AND IMPLANT DENTISTRY
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FAX COVER SHEET NOT REQUIRED
GENERAL DENTAL TREATMENT PLAN

Date: _____ Referring D.D.S.: _____

Patient Name: _____ DOB: _____ SS#: _____

Address: _____ City/State/Zip: _____

Home#: _____ Work#: _____ Cell#: _____ E-mail: _____

Insured's Name: _____ DOB: _____ SS#: _____

Insurance Name: _____ Phone#: _____

Employer: _____ Group #: _____

REASON FOR REFERRAL: **Implant** **Periodontal**

_ Periodontitis (Slight, Moderate, Severe) _____ _ Isolated Procedure # _____

_ Recession # _____ _ Implant # _____

_ Impressions Taken _____ _ Consultation _____

I AM SENDING: _ **Treatment Plan** _ **Probe Chart** _ **FMX** **Date Taken** _____

_ **BWX** _ **PAX** _ **PAN** _ **Diagnostic Models** _ **Have your office take necessary radiographs**

Please indicate the general dentistry you have recommended to our mutual patient. This information will be used to support the patient's completion of definitive dentistry in your office. (Please list appropriate teeth.)

RECOMMENDED TREATMENT PLAN MAY INCLUDE:

Operative # _____ Endodontics # _____

Crowns # _____ Occlusal Therapy # _____

Fixed Bridge # _____ Extractions # _____

Removable Partial Denture _____ Questionable Prognosis # _____

Last recall/hygiene date _____ Next recall/hygiene date _____

Next dental appointment _____

APPOINTMENT STATUS:

_ An appointment was made by our office: Date: _____ Time: _____

D.D.S.