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Date \_\_\_\_\_

This will introduce \_\_\_\_\_ Telephone \_\_\_\_\_

Referred by \_\_\_\_\_ Telephone \_\_\_\_\_

**Please evaluate:**

- ( ) General periodontal condition \_\_\_\_\_ ( ) For Edentulous Ridge Implants at \_\_\_\_\_  
( ) Local periodontal condition at \_\_\_\_\_ ( ) Immediate Extraction Implants at \_\_\_\_\_  
( ) For Crown Lengthening at \_\_\_\_\_ ( ) Pre Prosthetic Surgery at \_\_\_\_\_  
( ) Mucogingival Defect at \_\_\_\_\_ ( ) Pathology at \_\_\_\_\_  
( ) Esthetic Crown Lengthening at \_\_\_\_\_

Restorative Plans/Concerns: \_\_\_\_\_

**Radiographs:** ( ) Will be sent ( ) Radiographic/ surgical stent will be made by:  
( ) Should be taken ( ) Restorative dentist ( ) Periodontist

Fold here

**Please select implant preference:**

- ( ) Dentsply ( ) Straumann ITI ( ) Nobel Biocare  
( ) No Preference ( ) Please Call

**Type of temporization desired if needed:** ( ) Fixed ( ) Removable  
( ) Fabricated by Restorative Dentist ( ) Fabricated by Periodontist

**Circle one:**

Is the patient new to your office? Yes No

What type of maintenance is patient on? 3 month 4 month 6 month Infrequent

Does patient have any history of periodontal therapy? Yes No

If yes, please describe type of therapy and when \_\_\_\_\_

( ) Proceed with treatment, send initial treatment plan  
and therapy outcome reports.

( ) Please call before starting treatment.

Continued maintenance by: ( ) Periodontist ( ) General Dentist ( ) Alternating

( ) Please send more referral cards  
MAP ON BACK

