

*Susan Alexander* D M D

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Marietta, Georgia 30062

P E R I O D O N T I C S

REFERRED BY: \_\_\_\_\_

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

TELEPHONE: (MOBILE) \_\_\_\_\_

OTHER: \_\_\_\_\_

TENTATIVE DIAGNOSIS

RADIOGRAPHS

\_\_\_\_\_ GENERALIZED PERIODONTITIS

\_\_\_\_\_ NEEDED

\_\_\_\_\_ FORWARDED

\_\_\_\_\_ ISOLATED PERIODONTITIS

\_\_\_\_\_ FMX

\_\_\_\_\_ DATE

\_\_\_\_\_ MUCOGINGIVAL ONLY

\_\_\_\_\_ PA

\_\_\_\_\_ S & RP DATES

\_\_\_\_\_ IMPLANTS

\_\_\_\_\_ PAN

\_\_\_\_\_ OTHER

SPECIAL CONSIDERATION/COMMENTS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ PLEASE GIVE ME A CALL