



SCOTTSDALE
IMPLANTS &
PERIODONTICS ^{LLC}

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INTRODUCING PATIENT: _____

Date: _____ Patient Phone: _____

Referred by: _____

Radiographs: Required By Email

Preferred Implant System:  

REASON FOR REFFERAL:

- Full mouth / Comprehensive Evaluation
- Limited Evaluation
- Graft / Mucogingival Problem
- Crown Lengthening
- Esthetic Consultation
- Ridge Augmentation
- All on 4 Dental Implants
- Implant Consultation

AREAS OF CONCERN

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS OR SPECIAL INSTRUCTIONS
