

WEST VALLEY MEDICAL CENTER
5363 BALBOA BLVD., SUITE 226
ENCINO, CA 91316

Alfred Penhaskashi, D.D.S., Inc.
Periodontics, Laser & Dental Implant Center

TEL (818) 788-7091
FAX (818) 788-8876
www.minimallyinvasiveperio.com

INTRODUCING: _____ PHONE: _____

CONTACT PATIENT: YES NO

MY PATIENT REQUIRES:

- A COMPLETE PERIODONTAL EXAMINATION TO INCLUDE:
 - PERIODONTAL TREATMENT RECOMMENDATION
 - RESTORATIVE/PROSTHETIC RECOMMENDATIONS
 - IMPLANTS
- EMERGENCY TREATMENT

IMPLANT TYPES:

- NOBEL BIOCARE
- ASTRA
- STRAUMANN
- NEODENT

CONCERNS:

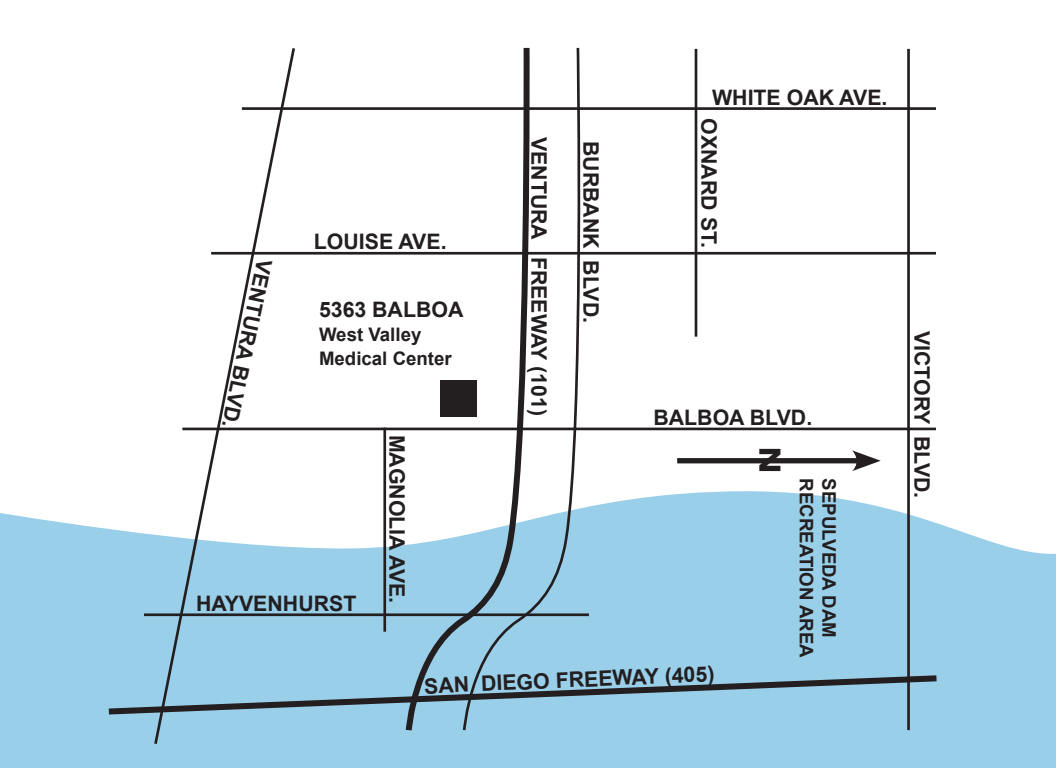
- | | | |
|-------------------------------------------|----------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> BONE LOSS | <input type="checkbox"/> RIDGE PRESERVATION | <input type="checkbox"/> ESTHETIC ROOT COVERAGE |
| <input type="checkbox"/> POCKETS | <input type="checkbox"/> IMPLANT | <input type="checkbox"/> ESTHETIC RIDGE AUGMENTATION |
| <input type="checkbox"/> MOBILITY | <input type="checkbox"/> SINUS AUGMENTATION | <input type="checkbox"/> FRENECTOMY & FIBEROTOMY |
| <input type="checkbox"/> RECESSION | <input type="checkbox"/> ONLAY-BLOCK GRAFT. | <input type="checkbox"/> ORTHO MINI IMPLANTS |
| <input type="checkbox"/> CROWNLENGTHENING | <input type="checkbox"/> ESTHETIC CROWNLENGTHENING | <input type="checkbox"/> ORTHO TOOTH EXPOSURE |

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

OTHER CONCERNS: _____

PLEASE CONTACT OUR OFFICE IF YOU HAVE A HISTORY OF RHEUMATIC FEVER, PROLAPSED MITRAL VALVE, HEART MURMUR OR PROSTHETIC JOINT REPLACEMENT. WE MAY NEED TO CONTACT YOUR PHYSICIAN TO DETERMINE IF ANTIBIOTIC PRE-MEDICATION IS NECESSARY BEFORE YOUR APPOINTMENT.

REFERRED BY: (PRINT NAME PLEASE) _____ DATE: _____



WHITE OAK AVE.

OXNARD ST.

BURBANK BLVD.

VENTURA
FREEWAY (101)

LOUISE AVE.

5363 BALBOA
West Valley
Medical Center



BALBOA BLVD.

VICTORY BLVD.



SEPUVEDA DAM
RECREATION AREA

MAGNOLIA AVE.

HAYVENHURST

SAN DIEGO FREEWAY (405)

VENTURA BLVD.

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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	

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THE PATIENT IS:

- NEW TO MY PRACTICE.
NUMBER _____ YEARS IN MY PRACTICE.
- ATTENDANCE HAS BEEN: REGULAR IRREGULAR

RECENT PERIODONTAL THERAPY: _____ (COMPLETED WITHIN LAST 2 YEARS)

SCALING (DATES) _____ SURGERY (DATES) _____

PLEASE CALL: BEFORE PATIENT CONSULTATION AFTER CONSULTATION

RESTORATIVE TREATMENT PLAN: _____

REMARKS: _____

Place
Stamp
Here

Alfred Penhaskashi, D.D.S., Inc.

Peridontics, Laser & Dental Implant Center

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