



SCHAUMBURG DENTAL IMPLANT CENTER

1701 E Woodfield Rd.
suit #510
Schaumburg, IL 60173
Phone: **847-637-5819**

CALL **847-637-5819** FOR AN APPOINTMENT

Patient Name: _____

Patient Phone: _____

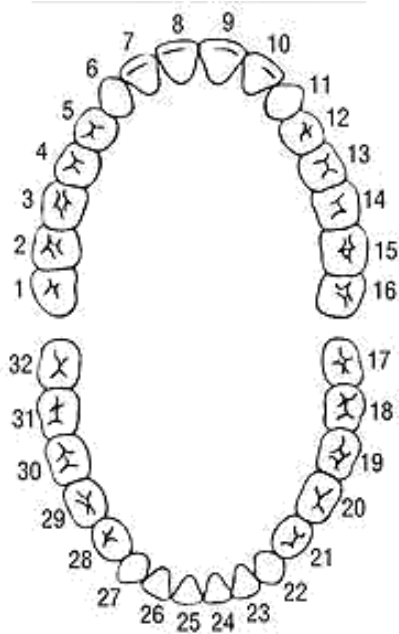
Referring Doctor: _____

Doctors Phone: _____

Service Requested:

- Single implant (no extraction)
- Evaluation of non-restorable tooth for extraction bone graft and implant placement
- Evaluation of one more teeth for implant bridge in a quadrant
- Full arch All-on Z™ implant placement with full fixed prosthesis (Zirconia full arch prosthesis)

Mark Areas Below (Circle area of interest and explain in notes)



REFERAL NOTES:

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Patient Name: _____ D.O.B. _____

Referring Doctor: _____

DOCTORS PORTION:

Brief Medical History

Any Significant medical history or allergies:

Does the patient have Diabetes?	Yes / No
Has the patient had Radiation from cancer treatment?	Yes / No
Does the patient take bisphosphonates?	Yes / No
Does the patient smoke you smoke?	Yes / No

Dental History upload or transfer

Is the patient receiving routine dental cleanings?	Yes / No
Does the patient have periodontal disease?	Yes / No
Is the periodontal status stable?	Yes / No
Do you have any outstanding treatment?	Yes / No

If Yes please explain:

* (Stable Periodontal status defined as little to no inflammation, PDs have been stable for a year, nothing over a 6mm pocket)

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