GRACE
PERIODONTICS & IMPLANTS

Wesam Salha, DDS, MSD
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Periodontist

Date: / /

Patient Name: _____

Home/Cell #: _____ Work #: _____

Reffered by Doctor & Office #: _____

Please Evaluate

☐ Full mouth perio evaluation

☐ Isolated area of periodontal breakdown-please circle

R 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 L

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Implant, Tooth #: _____ ☐ Place Final Abutment

Gingival grafting / contouring, tooth #: _____

Ridge / Sinus augmentation area : _____

Orthodontic co-therapy area : _____

Extract Tooth #: _____

Other : _____

X-rays - please email to info@graceperio.com

Comment : _____

_____

_____

_____

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