

# ASTORIA



PERIODONTICS AND IMPLANTS P.C.

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Introducing: \_\_\_\_\_ Referral is the courtesy of: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Address: \_\_\_\_\_

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: \_\_\_\_\_ Contact Phone: \_\_\_\_\_  Please call patient  Patient will call for appointment

Teeth # or area to be treated \_\_\_\_\_

**PLEASE CIRCLE TEETH / AREA TO BE TREATED**

### Procedure(s) Requested

- Extraction(s)
- Would you like us to discuss:  
implants or bone grafting? \_\_\_\_ Yes \_\_\_\_ No
- Biopsy / Excision
- Other: \_\_\_\_\_
- Alveoloplasty
- Frenectomy
- Exposure / Bond
- Incision / Drainage

Cone Beam CT Scan

### Consultation(s) Requested

- Dental implants
- Sinus Lift
- Bone grafting
- Facial Trauma
- Other: \_\_\_\_\_
- Oral Pathology
- Soft tissue grafting
- Skin lesions

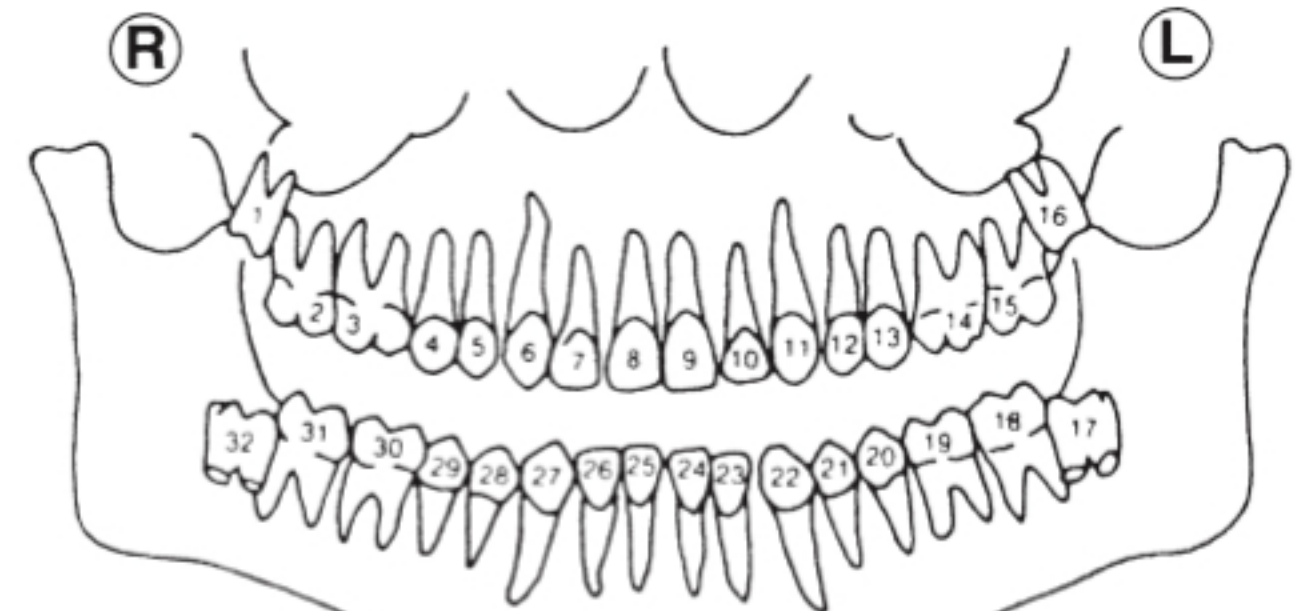
### Radiograph Requests

- Enclosed/Emailed
- Given to patient
- Please take new ones

### Management, Medical or Treatment concerns

\_\_\_\_\_  
\_\_\_\_\_

Please fax, mail, or email this form to the office.



(R) (L)

