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Patient Name: _____

Address: _____

Phone: _____

Has an appointment with your office for an examination for:

- | | |
|---|--|
| <input type="checkbox"/> Complete Periodontal Examination | <input type="checkbox"/> Mucogingival Deficiency |
| <input type="checkbox"/> Problem Focused Examination | <input type="checkbox"/> Cuspid Exposure |
| <input type="checkbox"/> Crown Lengthening | <input type="checkbox"/> Osseous Defect, Furcation Involvement |
| <input type="checkbox"/> Implants | <input type="checkbox"/> Other, Ridge Augmentation, etc... |

Special Considerations. Premed, Restorative, Dental Anxiety, Medically Compromised, etc...

Patient of Record: New #____years with practice? On Perio Maintenance Yes No

Radiographs: FMX - To Be Sent Need To Be Taken

Patient has completed soft tissue management program? Yes No

Root Planing / Curettage has been performed within the last year? Yes No

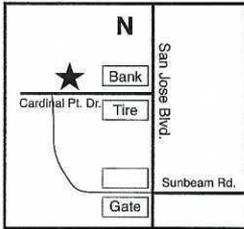
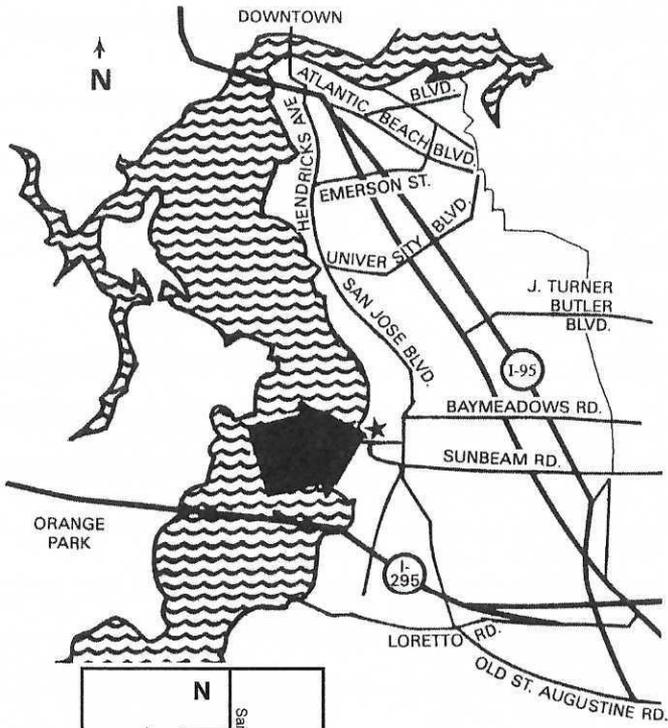
Restorative Treatment: Need additional treatment Needs treatment planning

Appointment Date _____ Time _____

Referring Doctor _____ Date _____

Please call regarding this patient.

Map on Reverse



3595 Cardinal Point Dr. One Block
 North of Sunbeam Rd. off of San Jose Blvd.
 (Rear entrance off of Sunbeam Rd.
 Past Gate Petroleum.)



NORTHEAST FLORIDA
Periodontics & Dental Implants

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