SOCALDSC™

CENTRAL DENTAL SPECIALTY CENTER

Practice limited to ***Periodontics & Implant Dentistry***

2711 Santa Ana Street
South Gate, CA 90280
Tel: 323.277.0600
Fax: 323.277.0606

Patient's Name: ______________________ Date ____________ for

☐ Periodontal Consultation / Treatment

☐ Gingival Graft

☐ Crown Lengthening Procedure

☐ Aesthetic Surgery Evaluation

☐ Oral Implant / Preprosthetic Surgery Evaluation

☐ CBCT Scan

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	

R	A	B	C	D	E	F	G	H	I	J	L
	T	S	R	Q	P	O	N	M	L	K	

Appointment Date: ______________________ Time: ____________ A.M. P.M.

Chief Complaint: ____

Special Instruction / Remarks: ________________________________

____

Current X-ray: ☐ Sent by mail ☐ Sent with Patient ☐ Please take one ☐ Please return

REFERRING DR.: ____

OFFICE PHONE NUMBER: __________________________________

PLEASE BRING THIS CARD WITH YOU, THANK YOU.