



NEWNAN
PERIODONTICS
AND
DENTAL IMPLANTS

MINDY S. GIL, DMD, DMSc
DIPLOMATE OF AMERICAN BOARD OF PERIODONTOLOGY

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info@newnanperio.com

Date: _____

From Dr: _____ Dr's Phone Number: _____

Introducing: _____

Reason for referral:

Area/Tooth #

- | | |
|--|-------|
| <input type="checkbox"/> Periodontal /Peri-implant Disease | _____ |
| <input type="checkbox"/> Extractions and/or Dental Implants | _____ |
| <input type="checkbox"/> Mucogingival Deformity:
<i>Recession or Hyperplastic Tissue</i> | _____ |
| <input type="checkbox"/> Crown Lengthening:
<i>Aesthetic or Pre-prosthetic</i> | _____ |
| <input type="checkbox"/> Frenectomy/ Functional Frenuloplasty:
<i>Buccal or Lingual</i> | _____ |
| <input type="checkbox"/> Oral Pathology:
<i>Dry Mouth, Burning Mouth Syndrome,
Suspicious Lesions</i> | _____ |
| <input type="checkbox"/> Airway
<i>Airway concerns, Snoring, Oral Appliance</i> | _____ |

Comments/Notes:

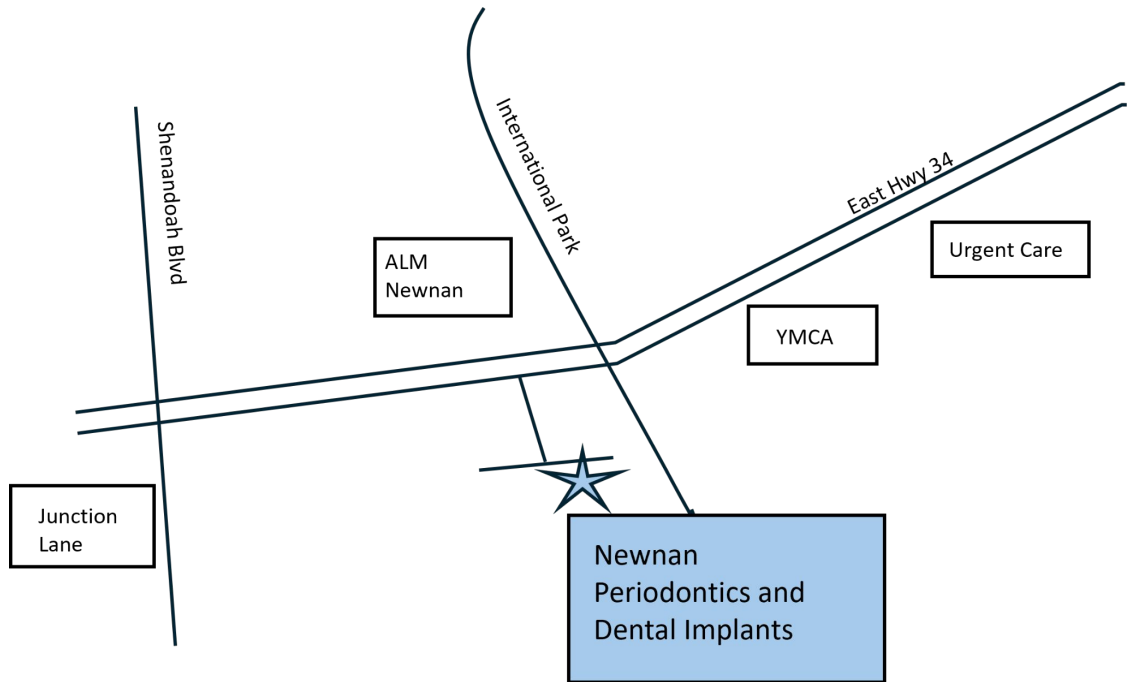


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We are located inside the White Oak Professional Center

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