Solid City Smiles

Comfort, Excellence, and Experience
in Periodontics and Dental Implants

Patient Name: _____

Patient phone +/or email:
(if you prefer for us to contact patient)

Referral for:

- ❑ Periodontal Disease
- ❑ Gingival/Gum Recession/Esthetics
- ❑ Pinhole Surgical Technique
- ❑ Implants, LAPIP, TeethXpress
- ❑ Laser surgery, LANAP
- ❑ IV Sedation
- ❑ check if patient has current x-rays
- ❑ check if doctor telephone consultation desired

Patient History and Area of Concern:

_____ _____

Referred by: ***Date:***

770.668.0604

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