



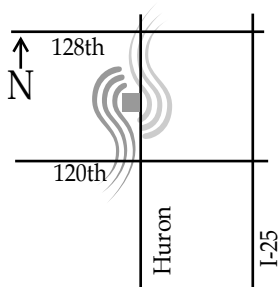
Christopher J. Sakkaris, DDS, PC
Diplomate of The American Board of Periodontology
Practice Limited to Periodontics, Implant and Laser Therapy

Date of Referral: _____

Referring Doctor: _____

Patient Name: _____

Appointment Time and Date: _____



Each consultation visit is a minimum of 40 minutes in duration. Please arrive 15 minutes prior to your appointed time for initial paperwork.

Please bring this referral card and any pertinent radiographs with you to your consultation appointment.

905 West 124th Avenue, Suite #150, Westminster, CO 80234

Office: 303.450.3144 Fax: 303.920.1136

www.sedonaperiodontics.com



Please evaluate for:

- | | |
|--|--|
| <input type="checkbox"/> Comprehensive Periodontal Exam
<input type="checkbox"/> Limited Periodontal Exam (please specify)
<input type="checkbox"/> Laser Periodontal Therapy
<input type="checkbox"/> Tooth Extraction

<input type="checkbox"/> Other : _____ | <input type="checkbox"/> Crown Lengthening
<input type="checkbox"/> Tissue Grafting
<input type="checkbox"/> Implant Evaluation
<input type="checkbox"/> Ridge Augmentation |
|--|--|

Radiographs: Enclosed/Attached With Patient

History of SRP _____

905 West 124th Avenue, Suite #150, Westminster, CO 80234

Office: 303.450.3144 Fax: 303.920.1136

www.sedonaperiodontics.com