SCOTT A. PAUL, D.D.S.

Periodontics / Implants

"Committed to Caring and Excellence"

2023 W. Vista Way, Suite L
Vista, CA 92083
(760) 630-8727 fax: (760) 631-1232

Date _____

Introducing _____ DOB _____

Home Phone _____ Work Phone _____

Referred By _____

APPOINTMENT INFORMATION: This time is reserved specifically for you. If by necessity, you must cancel your appointment, please notify us at least **two days** in advance.

Appt. Date _____ Time _____ Day _____

X-Rays: ☐ Being Mailed ☐ Given to Patient ☐ Please Take

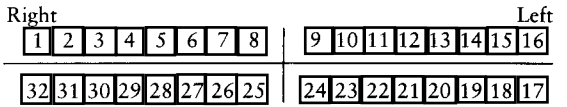
PROCEDURES (please indicate below and on diagram to the right)

- ☐ Complete Exam
- ☐ Limited Exam
- ☐ Implant Consult
- ☐ Gingival Grafting
- ☐ Frenectomy
- ☐ Hemisection / Root Amp
- ☐ Biopsy
- ☐ Fiberotomy
- ☐ Extraction w/ bone graft
- ☐ Other _____

*** Please see reverse side for map and patient instructions. ***

White-Patient's copy Yellow-Referring Office copy Card-Mail to our office

PLEASE CIRCLE TEETH OR AREA TO BE TREATED



Remarks or Special Instructions _____

_____

_____

_____

_____

_____

_____

☐ Pre-Med _____

☐ Health Advisory _____

_____

☐ Please send more referal pads.

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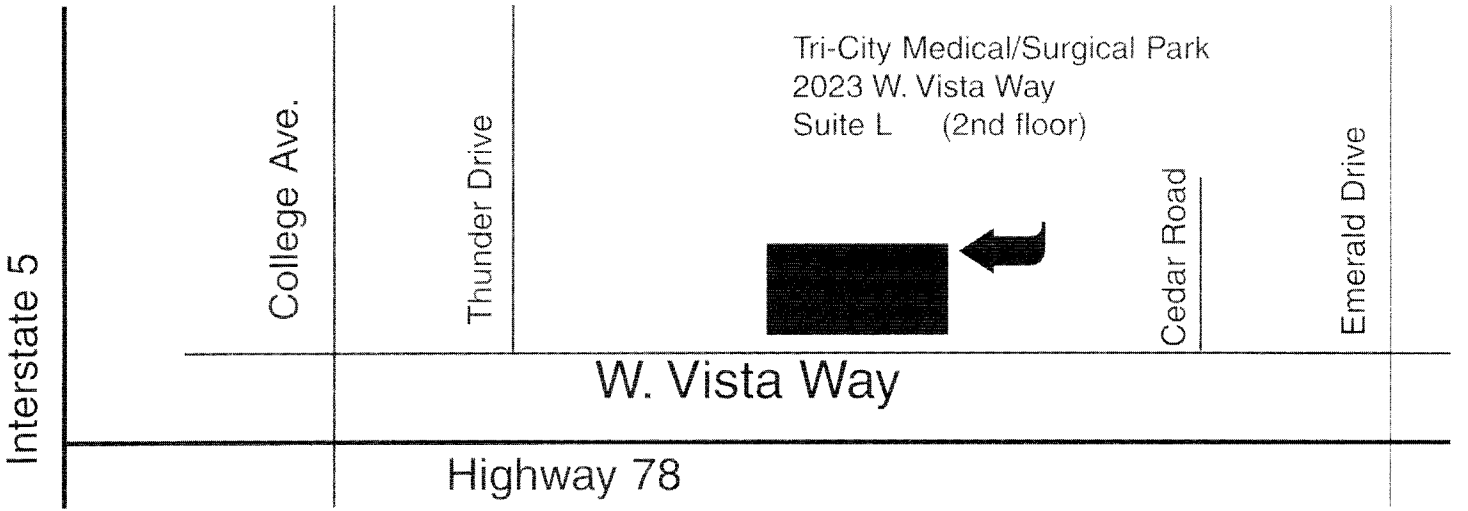

Dear Patient,

For your convenience, we will gladly mail you your new patient letter and forms for completion prior to your visits. If you have any questions prior to your consultation, please contact our office. We look forward to meeting you!

Scott A. Paul, D.D.S. and Staff