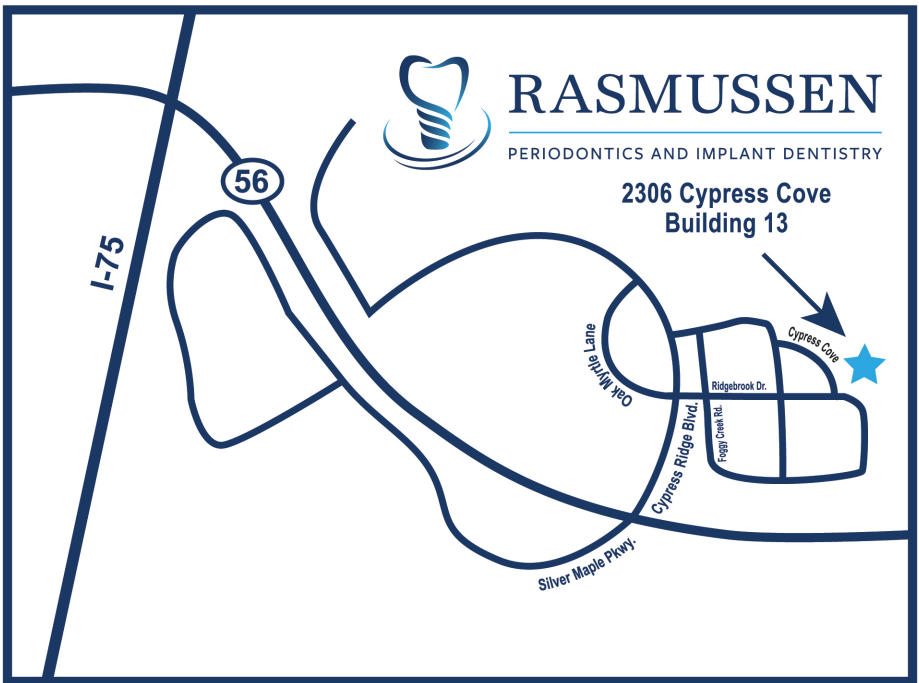


# APPOINTMENT

Date: \_\_\_\_\_

Time: \_\_\_\_\_



**Richard A. Rasmussen, III, DMD, MS**  
Diplomate, American Board of Periodontology

2306 Cypress Cove, Building 13 | Wesley Chapel, FL 33544

phone: 813-502-1302 | fax: 813-502-1301 | email: [info@rasmussenperio.com](mailto:info@rasmussenperio.com)

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# RASMUSSEN

PERIODONTICS AND IMPLANT DENTISTRY

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**rasmussenperio.com**

## PATIENT INFORMATION

Name: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
E-mail: \_\_\_\_\_

## REFERRING DOCTOR

Name: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
E-mail: \_\_\_\_\_

## AREAS OF CONCERN

- |  |   |
|--|---|
| <input type="checkbox"/> Extracton / Graft #:          | <input type="checkbox"/> Impacted Third Molars #:               |
| <input type="checkbox"/> Dental Implants #:            | <input type="checkbox"/> Ridge Augmentation #:                  |
| <input type="checkbox"/> Periodontal Disease #:        | <input type="checkbox"/> Sinus Augmentation: ___ Right ___ Left |
| <input type="checkbox"/> Recession Treatment #:        | <input type="checkbox"/> Tooth Exposure #:                      |
| <input type="checkbox"/> Crown Lengthening #:          | <input type="checkbox"/> Frenectomy:                            |
| <input type="checkbox"/> Esthetic Crown Lengthening #: | <input type="checkbox"/> Biopsy #:                              |
| <input type="checkbox"/> Biological Root Reshaping #:  | <input type="checkbox"/> Intravenous Sedation: ___ Yes          |
| <input type="checkbox"/> Guided Tissue Regeneration #: | <input type="checkbox"/> Laser Therapy #:                       |

## PRE-TREATMENT INFORMATION:

Please email all digital radiographs (FMX, PAs, BWX, PANO) to [info@rasmussenperio.com](mailto:info@rasmussenperio.com)

## RESTORATIVE PLANS AND NOTES:

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