

Patient Name: _____ Date: _____

Patient Phone Number: _____ Referring Doctor: _____

Tooth Number / Area: _____

Please perform the following services:

- Consultation and treatment as necessary
- Please call after consultation - prior to treatment
- Complete periodontal examination
- Limited periodontal examination
- Soft tissue graft (Recession)
- Crown Lengthening
- PRF (Plasma Rich Growth Factor)
- GBR (Guided Bone Regeneration)
- Vertical Bone Augmentation
- Pinhole Rejuvenation

Imaging Only:

- Panoramic radiograph
- CT scan
- TRIOS intraoral scanner

Implant evaluation:

- Single tooth replacement
- Zirconia implant (All-ceramic implant)
- All-on-X (4 or 6)
- Implant supported overdenture

Laser Procedures:

- LAPIP (Peri-Implantitis Treatment by Laser)
- LANAP (Laser Assisted New Attachment Procedure)
- Laser skin resurfacing
- Facial microneedling with PRF

Comments or Restorative Plan:

DIRECTIONS



MISSION IMPLANT CENTER

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