# Sarah Stipho DMD, MS

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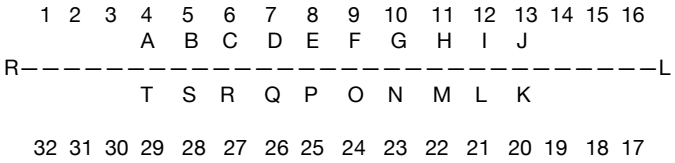
Introducing:_____Date of Birth:_____
Referred by Dr._____

Referring Office Name/Address:

_____
_____
_____

Please circle areas to be evaluated:




Procedures:

- ☐ Consultation
- ☐ Implants
- ☐ Extraction
- ☐ Oral pathology/biopsy
- ☐ Bone grafting
- ☐ Gum recession treatment
- ☐ Tori removal/alveoplasty
- ☐ Other:_____
- ☐ Crown lengthening
- ☐ Osseous/pocket reduction surgery
- ☐ Regenerative procedures
- ☐ Temporary anchorage device
- ☐ Surgical exposure of teeth
- ☐ Frenectomy
- ☐ Botox treatment

Notes:

_____
_____
_____

Imaging:

- ☐ x-ray mailed /e-mailed
- ☐ x-ray sent with patient
- ☐ photo
- ☐ Take cone beam CT
- ☐ Take panoramic x-ray