Shakeel Khan DDS MSD

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PERIODONTICS AND IMPLANT SOLUTIONS
Shakeel Khan DDS, MS

Patient Name _____ Phone _____ Date _____

Referral Information

Please check all that apply

- ☐ Comprehensive periodontal evaluation
- ☐ Perio-ortho _____
- ☐ Limited evaluation # _____
- ☐ Gingival contour/augmentation _____
- ☐ Oral medicine/biopsy _____
- ☐ Crown lengthening _____
- ☐ Other _____
- ☐ Implant consultation # _____
- ☐ Full arch _____

Preferred implant system: ☐ Zimmer (ZimVie) ☐ Nobel ☐ No preference

Restorative needs: ☐ Final scan ☐ Provisionalized

Preferred lab: _____ Shade _____

Referring Dentist Information

Name _____

Preferred method of communication:

☐ Email _____ ☐ Text _____ ☐ Phone _____

Please call me to discuss ☐ before ☐ after seeing the patient

I will send ☐ FMX ☐ CBCT/pano or

Please take ☐ FMX ☐ CBCT/pano and send to your office with follow-up email letter.