DR. NICOLE L. MANTHA

BSc, DDS, Cert. Perio., MRCD(C)
Specializing in PERIODONTICS
Dentistry Professional Corporation

Dr._____ Office Name:_____
First Name Last Name

Introducing: (first name)_____ (last name)_____

address: _____

town: _____ postal code: _____

cell phone:_____ email:_____

date of birth ___ / ___ /_____
M D Y

Please see this patient regarding:

☐ Comprehensive periodontal exam (indicate below periodontal disease diagnosis)

☐ Early ☐ Moderate ☐ Advanced

Treatment Required:_____

☐ Other / Specific problem area: _____

Treatment Required:_____

_____

☐ Patient needs prophylactic antibiotics, specify:_____

☐ ***Please send latest probing depths for CDCP patients only***

Patient's last cleaning at your office: _____

☐ Radiographs are attached

Insurance Information

Policy Holder's Name: _____ D.O.B.:_____

Name of insurance company: _____ Group #: _____

I.D #: _____ Employer: _____

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