



Michael K. Setter D.D.S., M.S.D., L.L.C.

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Phone: 503.222.9961

Patient's Name: _____

Patient Phone: _____

Referred by Dr.: _____

Date: _____

Next Appointment:

- Made for patient: Date: _____ Time: _____
- Please call patient to schedule first appointment
- Patient instructed to call for appointment

Please perform:

- Comprehensive Periodontal Examination**
Please forward recent full-mouth series (FMX) and periodontal charting
- Limited Periodontal Examination for teeth #'s :** _____
Please forward recent radiographs (BW & PA) and periodontal charting

For all periodontal/gingival recession patients:

- Date of most recent prophylaxis/periodontal maintenance: _____
- Scaling/Root Planing performed: Yes No Date: _____ Area: _____
- Limited Exam for Dental Implants for teeth #'s:** _____
Please forward recent radiographs (PA and/or Pano)
- Limited Exam for:** **Crown Lengthening** **Gingival Recession** **Other** _____
Tooth #: _____

Radiographs: Date Taken: _____ Type: PA BW Pano FMX

- E-mailed to frontdesk@setterperio.com
- Sent with patient
- Please take pertinent radiographs

Restorative Treatment:

- Is planned for: _____
- Will be planned after periodontal evaluation
- Is not indicated or planned at this time

Comments:
