



SFimplants & perio

TERRY IM, DDS, MS
ADRIENNE GUNSTREAM, DDS, MS

450 Sutter St., Ste. 2329
San Francisco, CA 94108

t: **415.397.4095** | f: 415.397.4050
sfimplantsandperio@gmail.com
www.sfimplantsandperio.com

We would like to welcome you to our office. Your dentist has already advised you that you may have periodontal (gum) disease. Your initial visit to our office will consist of a thorough medical and dental history and a complete mouth examination. After a diagnosis is made, we will discuss with you the treatment plan, and present an estimate of the fee and time involved in the treatment. You are encouraged to ask any questions you have regarding your problem and the proposed treatment. If you wish, you may bring your spouse or a close family member along to the consultation.

We look forward to meeting you.

Patient Name _____

Cell Phone _____ Home _____

Appointment Date _____ Time _____

Referring Doctor _____ Date _____

EXAM: Complete Emergency Implant Grafting
 Special Concern: _____

XRAYS: Enclosed To be mailed/emailed Patient will bring

PATIENT HAS RECEIVED:

- Explanation of problem Root Planing
- Prophylaxis Previous Perio Surgery
- General dentist would like to do the root planing

Restorative Treatment Planned: _____

Special Comments: _____
