



WHITTIER DENTAL SPECIALISTS CENTER

Practice limited to *Periodontal & Implant Dentistry*
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PLEASE BRING THIS CARD TO YOUR APPOINTMENT

Date: _____

Patient Name: _____

Appointment Date: _____ Time: _____ AM/PM

Referring Dentist: _____ Office Phone Number: _____

Consultation Only

Consultation and Treatment

Service Requested:

- Full Mouth Periodontal Evaluation & Tx
- Isolated Periodontal Evaluation & Tx
- Osseous Surgery
- Recessional/Gingival Grafting
- Bone Grafting
- Crown Lengthening
- Gingivectomy
- Cuspid Exposur
- Implant Consultation

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	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

- Full Mouth
- Upper Right (UR)
- Upper Left (UL)
- Lower Right (LR)
- Lower Left (LL)

Periodontal Treatment Previously Done:

- Scaling & Root Planing: **UR LR UL LL**
- Date Completed: _____
- Frequent Periodontal Maintenance

Comments: _____

White Copy: Give to Patient

Yellow Copy: Keep in office