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Introducing: \_\_\_\_\_ who has an appointment \_\_\_\_\_

DAY DATE TIME

Patient's Contact Phone: \_\_\_\_\_ Referring doctor: \_\_\_\_\_ Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Consultation/Procedures Required:**

Generalized periodontal workup

Isolated periodontal procedures Teeth # \_\_\_\_\_

Crown lengthening Teeth # \_\_\_\_\_

Soft tissue graft Teeth # \_\_\_\_\_

Dental implant Teeth # \_\_\_\_\_

Other: \_\_\_\_\_

**Radiographs:**

Enclosed  Emailed  Given to patient  Take as needed

**Additional Information:**

Date of last FMX: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  None

Dates of scaling and root planing: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Teeth# scaled: \_\_\_\_\_

Restorative plan: \_\_\_\_\_

Additional Remarks/Concerns: \_\_\_\_\_

Please email or fax this form to the office