



PERIODONTAL
ASSOCIATES
OF LAFAYETTE

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415 North 26th Street, Suite 303 • Lafayette, IN 47904

www.perioal.com

(765) 447-9319

Date: _____

(765) 447-7227 FAX

Introducing _____

Patient Phone # _____

Referred by Dr. _____

☐ Comprehensive Periodontal Examination

☐ Limited Examination: Area _____

☐ Crown Lengthening

☐ Bone Loss

☐ Frenum

☐ Gingival Graft

☐ Implant Examination: Area _____

☐ Other _____

Radiographs:

☐ Please take full mouth survey

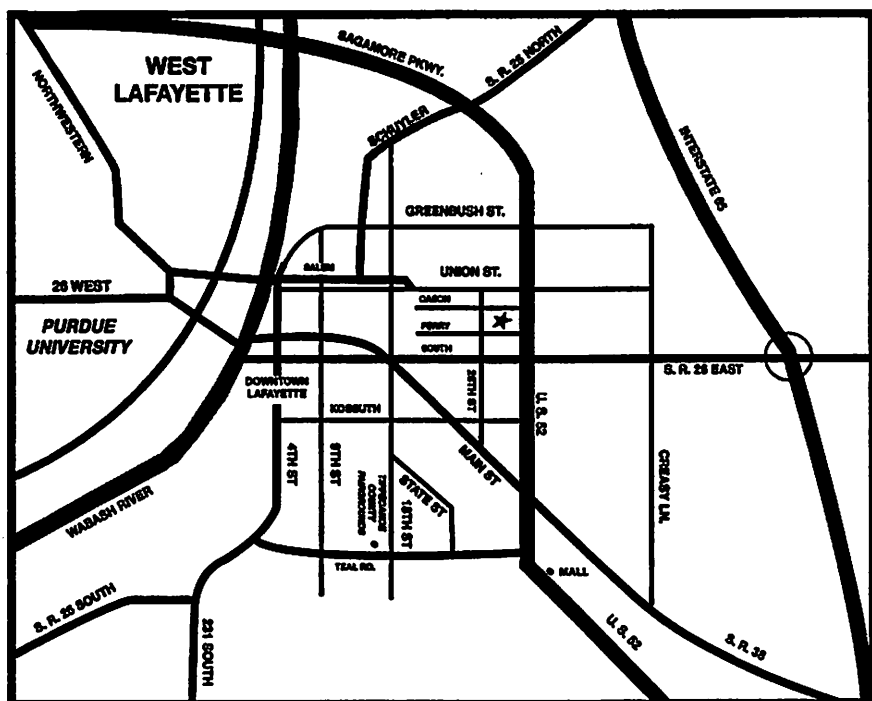
☐ Please take x-ray of area

☐ We are sending x-ray(s)

Comments: _____

Appointment Time and Date: _____

TO EXPEDITE YOUR REGISTRATION, PLEASE VISIT OUR WEBSITE, **PERIOAL.COM**,
TO SUBMIT YOUR PATIENT REGISTRATION FORMS PRIOR TO YOUR VISIT.



★ 415 North 26th Street,
Suite 303

