MUTUAL PATIENT CORRESPONDENCE

DOMINIK DUBRAVEC, DDS, MMSc
PERIODONTICS IMPLANT DENTISTRY ORAL MEDICINE

Frankfort: 815-464-3001
Kankakee: 815-932-0554
Oak Brook: 630-573-0369
www.periodontalspecialty.com

General Dentist: _____

Patient Name: _____

Date: _____

RADIOGRAPHS:

- ❑ CT Scan (Date Taken: _____)
- ❑ FMX (Date Taken: _____)
- ❑ BWX (Date Taken: _____)
- ❑ Panorex (Date Taken: _____)
- ❑ Please Take Needed Radiographs
- ❑ PAX (Date Taken: _____)
- ❑ Other (Date Taken: _____)

RESTORATIVE THERAPY:

- ❑ Is Planned
- ❑ Is Not Indicated
- ❑ Will Be Planned After Evaluation

COMMENTS (optional): _____

❑ **Please contact me regarding this patient.**