



ASPIRE
IMPLANTS AND PERIODONTICS

Board certified in periodontics and dental implant surgery

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APPT. DATE: _____ TIME: _____

REFERRED BY: _____ DATE REFERRED: _____

PATIENTS NAME: _____ DATE OF BIRTH: _____

PATIENTS HOME PHONE: _____ CELL PHONE: _____

Reason for Referral:

- Comprehensive Periodontal Exam & Consultation
- Implant Exam & Consultation
- Sinus Lift/Implant Site Development
- Soft Tissue Grafting/Recession
- Isolated Periodontal Concern
- Peri-Implant Disease/Implant Repair
- Other

XRays:

- Provided w /Referral:**
 - FMX
 - PA & BWX
 - Panoramic
- Take Necessary XRays**

Please circle the areas of involvement:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

MEDICAL ALERT: _____

COMMENTS/RESTORATIVE PLANS:

