



**EHSAN REZVAN, DDS, MS, INC.**  
**PERIODONTIST**

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Dr. Ehsan Rezvan

Dr. Lindsey Williams

Today's Date: \_\_\_\_\_ Appt. Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
First Last

Patient's Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Referred By: \_\_\_\_\_

Reason for Referral-Specific Areas of Concern:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
<b>R</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>L</b>
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

**PERIODONTAL THERAPY**

- |  |  |
|--|--|
| <input type="checkbox"/> Complete Periodontal Exam & Treatment | <input type="checkbox"/> Wisdom Teeth Evaluation |
| <input type="checkbox"/> Localized/Limited Exam & Treatment    | <input type="checkbox"/> Regeneration            |
| <input type="checkbox"/> Crown Lengthening                     | <input type="checkbox"/> Periodontal Bone (GTR)  |
| <input type="checkbox"/> Soft Tissue Grafting                  | <input type="checkbox"/> Gingivectomy            |
| <input type="checkbox"/> Extractions                           | <input type="checkbox"/> Other: _____            |

**IMPLANT THERAPY**

- |  |  |
|--|--|
| <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Socket Preservation (GBR) |
| <input type="checkbox"/> Sinus Grafting  | <input type="checkbox"/> Ridge Augmentation        |

**OTHER SERVICES**

- |  |  |
|--|--|
| <input type="checkbox"/> i-CAT                   | <input type="checkbox"/> Tooth Exposure      |
| <input type="checkbox"/> Itero Scan              | <input type="checkbox"/> Frenulectomy        |
| <input type="checkbox"/> Soft/Hard Tissue Biopsy | <input type="checkbox"/> IV or Oral Sedation |
| <input type="checkbox"/> Orthodontic             | <input type="checkbox"/> Other: _____        |

**RECENT FULL MOUTH RADIOGRAPHS**

- |   |   |
|---|---|
| <input type="checkbox"/> Available, date taken: _____ | <input type="checkbox"/> Unavailable, please take new radiographs |
| <input type="checkbox"/> Patient will bring           | <input type="checkbox"/> Emailed to office                        |
|   | <input type="checkbox"/> Mailed to office                         |

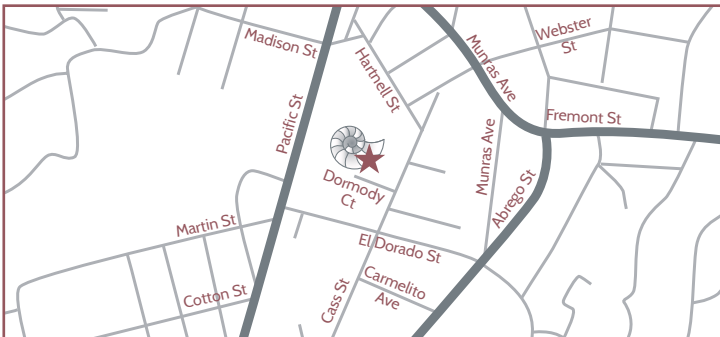
Special Instructions or Comments: \_\_\_\_\_



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## RECENT FULL MOUTH RADIOGRAPHS

Please assist us at the time of your initial visit to the office by providing the following information:

- Your referral slip and x-rays from your referring dentist.
- A list of medications you are currently taking (please note that you can fill out your patient registration and medical history form on our website).
- If you have dental insurance, please bring any forms or insurance cards with you to the appointment.

Please note: All patients under 18 must be accompanied by a parent or guardian at the consultation appointment.

Please notify the office if you have a medical condition or concern prior to surgery (e.g. artificial heart valves or joints, heart murmurs requiring pre-medication, severe diabetes, or hypertension).