GALLERIA
PERIODONTICS & IMPLANTS

Wesam Salha DDS. MSD.
Periodontist

Date: / /

Patient Name: _____

Home/Cell #: _____ Work #: _____

Referred by Doctor & Office #: _____

Please Evaluate

☐ Full mouth perio evalution

☐ Isolated area of periodontal breakdown-please circle

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

Implant, Tooth #: _____ ☐ Place Final Abutment

Gingival grafting / contouring, tooth #: _____

Ridge / Sinus augmentation area : _____

Orthodontic co-therapy area : _____

Extract Tooth #: _____

Other : _____

X-rays - please email to info@galleriaperio.com

Comment : _____

5858 Westheimer Rd, Suite 820, Houston, TX 77057

www.Galleriaperio.com info@galleriaperio.com (713) 784-6065