Cityview
PERIODONTAL CENTRE

JILL BASHUTSKI, DDS MS FRCD(C) AND ASSOCIATES

PATIENT INFORMATION

Name _____

Birthdate _____

Phone _____

Email _____

REFERRED BY

Name _____

Phone _____

Date _____

REFERRED FOR

TOOTH #/AREA (S): _____

- ☐ GENERALIZED PERIO
- ☐ GINGIVAL GRAFTING/MAG/RECESSION
- ☐ FRENECTOMY
- ☐ CROWN LENGTHENING
- ☐ IMPLANTS
- ☐ TOOTH EXPOSURE
- ☐ PERIO SPECIFIC SITE
- ☐ BIOPSY
- ☐ EXTRACTIONS
- ☐ BONE GRAFTING/SINUS LIFT
- ☐ 3D CBCT IMAGING
- ☐ OTHER

COMMENTS _____

_____

PREFERRED IMPLANT TYPE:

- ☐ Straumann bone level
- ☐ Straumann tissue level
- ☐ Nobel Biocare conical connection (Active)
- ☐ Nobel Biocare Trilobe connection (Groovy, Replace Select, etc.)
- ☐ Astra
- ☐ Avinent
- ☐ Implant One

reception@cityviewperio.com www.cityviewperio.com
400-2550-15th Ave, Regina, SK, S4P 1A5

Tel. (306) 525-9620
Fax (306) 347-3066

Cityview
PERIODONTAL CENTRE

HYGIENE RECALLS (after treatment is complete)

☐ At our office ☐ Cityview Periodontal Centre ☐ Please recommend

DENTAL INSURANCE

*SK Heatlh Card #*_____

Primary Dental Insurance
Name of Insured: _____
Relationship to Patient: _____
Insured Date of Birth:_____
Insurance Co: _____
Group/Policy#: _____
Cert/ID#: _____
Div#: _____

Secondary Dental Insurance
Name of Insured: _____
Relationship to Patient: _____
Insured Date of Birth:_____
Insurance Co: _____
Group/Policy#: _____
Cert/ID#: _____
Div#: _____

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