

PRACTICE LIMITED TO  
PERIODONTICS AND ORAL MEDICINE

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Date: \_\_\_\_\_

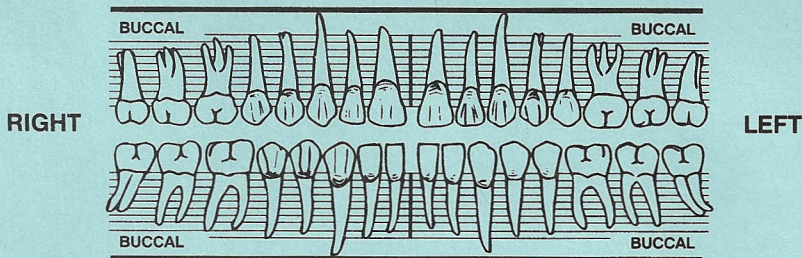
PATIENTS NAME: \_\_\_\_\_

PATIENTS PHONE (HOME): \_\_\_\_\_ (BUSINESS) \_\_\_\_\_

REFERRING DENTIST: \_\_\_\_\_

**REFERRAL REQUESTED**

- A) General Evaluation for Periodontal needs \_\_\_\_\_
- B) Implants \_\_\_\_\_
- C) Muco-Gingival problems \_\_\_\_\_
- D) Crown lengthening procedure \_\_\_\_\_
- E) TMJ and / or MFP evaluation \_\_\_\_\_
- F) Evaluation of oral lesion \_\_\_\_\_
- G) Emergency Periodontal problem area \_\_\_\_\_
- H) Other \_\_\_\_\_



X-Rays being sent \_\_\_\_\_ BWX \_\_\_\_\_ FMX \_\_\_\_\_

- I have not as yet proposed a definitive restorative treatment plan to the patient
- I have tentatively proposed the following treatment plan to the patient. Please evaluate the circled teeth as possible abutments for (fixed) or (removable) prosthetics.