

**CHLOE COHEN, D.D.S., M.S.**  
**CHLOE COHEN, D.D.S., A DENTAL CORPORATION**

*PERIODONTICS - DENTAL IMPLANTS*

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Introducing: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by Dr. \_\_\_\_\_ Date: \_\_\_\_\_

**PERIODONTAL CONSULTATION**

**DENTAL IMPLANT(S) CONSULTATION**

**COSMETIC CONSIDERATIONS**

CONCERNS:     bone loss                       pockets                       mobility                       inflammation  
                   recession                       frenectomy                       biopsy                       ridge augmentation  
                   crown lengthening                       other \_\_\_\_\_

right 

1	2	3	4	5	6	7	8
32	31	30	29	28	27	26	25

 | 

9	10	11	12	13	14	15	16
24	23	22	21	20	19	18	17

 left                      (circle area/teeth)

Recent full mouth X-rays (ARE) (ARE NOT) available     e-mailed                       mailed                       with patient

Recent Periodontal Therapy                      Scaling (dates)                      Surgery (dates)  
(last 3 years by quadrant)                      \_\_\_\_\_ | \_\_\_\_\_                      \_\_\_\_\_ | \_\_\_\_\_

Comments: \_\_\_\_\_

Please e-mail to [chloecohendds@gmail.com](mailto:chloecohendds@gmail.com) or fax to (310) 432-0762