CLINICAL FINDINGS FOR
SURGICAL PERIO BENEFITS DETERMINATION

“I attest to the accuracy of the information based upon my clinical evaluation and chart review. All of these findings are documented in the patient’s records.”

Dentist Signature: ___________________________________________ Date: __________________________

Patient Name: ____________________________________________

Tooth/Area: _______ Proposed Treatment: _______________________________________________________________________

Tooth/Area: _______ Proposed Treatment: _______________________________________________________________________

Tooth/Area: _______ Proposed Treatment: _______________________________________________________________________

Tooth/Area: _______ Proposed Treatment: _______________________________________________________________________

Patient’s periodontal disease diagnosis: ________________________________

Additional diagnoses: __________________________________________________________________________________________

Date of initial evaluation/charting: ________________________________

Date(s) of scaling/root planing: _____________

UR _____________

UL _____________

LL _____________

LR _____________

Date of reevaluation/charting: ________________________________

ADDITIONAL SUPPORTING DOCUMENTATION ENCLOSED:

☐ Periodontal chart

☐ X-rays

☐ Chart notes

☐ Narrative

☐ Clinical/Intraoral photographs

BONE PATHOLOGY

☐ Horizontal bone loss in these areas: ______________________________________________________________

☐ Vertical bone loss or defects in these areas: ________________________________________________________

☐ Loss of lamina dura integrity in these areas: ________________________________________________________

☐ Other bone pathology: __________________________________________________________________________

TOOTH PATHOLOGY

☐ Tooth #____ fractured below gingival attachment level.

☐ Tooth #____ has caries below gingival attachment level.

☐ Other tooth pathology: __________________________________________________________________________

SOFT TISSUE PATHOLOGY

☐ Gingival hyperplasia/overgrowth in these areas: ____________________________________________________

☐ Gingival margin recession in these areas: ____________________________________________________________

☐ Lack of attached gingiva in these areas: _____________________________________________________________

☐ Cosmetic gingival recontouring desired in these areas: ________________________________________________

☐ Frenum attachment in this area ________ is causing this problem: ________________________________

☐ Other soft tissue pathology: ______________________________________________________________________

EXTRACTIONS

☐ These teeth are treatment planned to be extracted: __________________________________________________

☐ These teeth are currently missing: __________________________________________________________________

BONE GRAFTING

☐ Being done for periodontal defects on these teeth: __________________________________________________

☐ Being done for periimplant defects on these implants: ________________________________________________

☐ Being done at the same time as placement of these implants: _________________________________________

☐ Being done for ridge preservation during extraction of these teeth or implants: __________________________

☐ Being done to augment sinus cavity via a sinus lift