HIGHLAND
IMPLANT CENTER

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(919)706-1701
info@highlandimplantcenter.com

PATIENT INFORMATION

Full Name _____

Date of Birth ____ /____ /____ **Gender** ◯ Male ◯ Female

Phone Number _____ **Email** _____

Referring Provider _____ **Phone Number** _____

REASON FOR REFERRAL

Please check all that apply.	Details:
◯ Oral Surgery Consultation	◯ Tooth Extraction/Grafting (Single/Multiple)
◯ Dental Implants	◯ Implant Placement (Single/Multiple)
◯ Full Mouth Rehabilitation	◯ Full Arch Implants (All-on-4)
◯ Bone Grafting	◯ Sinus Lift, Ridge Augmentation
◯ TMJ Disorders	◯ Jaw Joint/Temporomandibular Issues
◯ Facial Trauma	◯ Fractures, Soft Tissue Injuries
◯ Periodontal Surgery	◯ Crown Lengthening
◯ Sedation Consult	◯ IV/Nitrous Sedation
◯ Other:	◯ Other:

Preferred Office Location ◯ Raleigh ◯ Zebulon

MEDICAL HISTORY

Notes/Concerns (Please indicate any relevant medical conditions, allergies, or treatments)

_____

_____

_____

IMPLANT-SPECIFIC INFORMATION

Current Prosthetic Status (e.g., removable, fixed partial, full denture):

_____

Bone Loss/Condition (If known):

_____

Prior Treatments/Surgeries:

_____

Current Medications (Important for surgical planning):

_____

Smoking History (Yes/No, or current smoker):

_____