



**DR. ERIC ANDERSON**

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Colorado's *only* board certified periodontist specializing in gingival grafting and esthetics

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

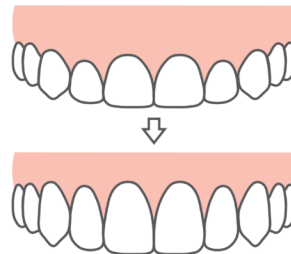
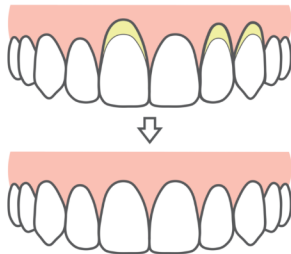
Patient Phone Number \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Hygienist \_\_\_\_\_

1	2	3	4	5	6	7	8	:	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	:	24	23	22	21	20	19	18	17

Reason for Referral

Gingival Recession # \_\_\_\_\_  Anterior Crown Lengthening # \_\_\_\_\_



Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please send recent radiographs. An FMX would be appreciated if you have one.**