

# ORAL HEALTH ESSENTIALS

## PERI-IMPLANTITIS THERAPY PROGRAM

Patient Name: \_\_\_\_\_

**First Therapy Appointment** (Date \_\_\_\_\_ / \_\_\_\_\_ min/hr)

<b>In-office</b>	_____ min/hr	Oral Health Instruction and Patient Education	\$ _____
	_____ min/hr	Debridement (at implant site with freezing)	\$ _____
	_____ min/hr	Subgingival Irrigation (if required)	\$ _____
	_____ min/hr	Subgingival Administration of Locally Delivered Anti-microbials (if required)	\$ _____
	_____ min/hr	Prescription of Systemic Antibiotics (7-10-day cycle)	\$ _____
<b>At-home</b>	_____ unit	Oral Health Essentials Patient Home Care Kit	

Subtotal: \$ \_\_\_\_\_

**Second Therapy Appointment** (7-10 days later \_\_\_\_\_ min/hr)

_____ min/hr	Specific Exam (assess implant site for improvements)	\$ _____
_____ min/hr	Oral Hygiene Review	\$ _____

Subtotal: \$ \_\_\_\_\_

**Third Therapy Appointment** (4-6 weeks later \_\_\_\_\_ min/hr)

_____ min/hr	Specific Exam (assess bleeding, gum health, and oral hygiene/plaque score)	\$ _____
_____ min/hr	Debridement (at implant site, if needed)	\$ _____
_____ min/hr	Other (surgical intervention is required in advanced cases) _____	\$ _____
_____ min/hr	Oral Hygiene Review	\$ _____

Subtotal: \$ \_\_\_\_\_

Reset

TOTAL: \$ \_\_\_\_\_

May require a specialist referral if symptoms persist or if any advanced implant disease develops.