REFERRAL FOR PERIODONTAL EVALUATION

Referred By:

Doctor's Name _____ Phone _____ Fax _____

Dental Office Email _____ Date _____

Introducing My Patient:

Patient Name _____ Gender ❑ Male ❑ Female DOB _____

Email Address _____ Work Phone _____ Cell Phone _____

Date of Scheduled Appointment _____ Home Phone _____

Medical Alerts/Allergy _____ ❑ Call our Patient for an Appointment

_____

_____

Radiographs:

❑ Mailed With the Referral ❑ Attached to this Online Form

Reason for Referral:

Proposed Site(s) _____

Site Status:

Edentulous Site(s) _____ Extraction Planned/Done # ____ Date: _____

_____ Extraction Requested # _____ +/- Immediate Placement

_____ Restorative Abutment Connection Requested ❑ Yes ❑ No

Comprehensive Periodontal Exam:

Specific Periodontal Exam (check box & indicate tooth #)

❑ ____ Crown Lengthening ❑ ____ Recession/Keratinized Tissue ❑ ____ Ridge Augmentation ❑ ____ Sinus Augmentation

❑ ____ Unerupted Tooth Exposure ❑ ____ Aesthetic Gingival Grafting

Other _____

_____

Restorative Plan / Comments _____

_____

Other Medical Concerns or Special Considerations _____

_____

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Dental Implant Surgery

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