REFERRAL FOR PERIODONTAL EVALUATION

REFERRED BY

Doctor's Name ______ Date ______

Phone ______ Fax ______ Email ______

INTRODUCING MY PATIENT

Patient's Name ______ ☐ Male ☐ Female

Email Address ______ DOB ______

Home Phone ______ Work ______ Cell ______

Date of Scheduled Appointment ______ ☐ Please call our patient to schedule an appointment

Medical Alerts/Allergies/Concerns ______

Radiographs ☐ Mailed with the Referral ☐ Attached to this Online Form

REASON FOR REFERRAL

☐ **DENTAL IMPLANT CONSULT**

Proposed Site(s) ______

SITE STATUS *(check box & indicate tooth #)*

Edentulous Site(s) ______

☐ ______ Extraction Requested ☐ Immediate Placement

☐ ______ Extraction Planned ☐ Extraction Completed

Restorative Abutment Connection Requested ☐ Yes ☐ No

Date of Extraction ______

☐ **COMPREHENSIVE PERIODONTAL EXAM**

☐ **SPECIFIC PERIODONTAL EXAM** *(check box & indicate tooth #)*

☐ ______ Ridge Augmentation ☐ ______ Recession/Keratinized Tissue ☐ ______ Crown Lengthening

☐ ______ Sinus Augmentation ☐ ______ Aesthetic Gingival Grafting ☐ ______ Unerupted Tooth Exposure

☐ Other ______

COMMENTS

Restorative Plan / Additional Notes ______

Thank you for the confidence of your referral.

DR. DAVID FRENCH

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Dental Implant Surgery.

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