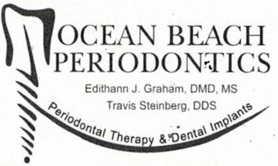

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Periodontics & Dental Implants

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Date:________________

Introducing:______________________________________

Patient Phone:____________________________________

Referred By:______________________________________

Date Referred:____________________________________

Last Treatment in your office was for:____________

____

Reason For Referral

☐ Periodontal Evaluation
☐ Bone Grafting
☐ Gingival Grafting
☐ Implant
☐ Emergency Visit
☐ Crown Lengthening
☐ Root Planing
☐ Extraction

Radiographs (Please e-mail)

☐ Given to Patient ☐ Please Take ☐ Being Mailed
☐ Last FMX / PA / BW Radiograph

Date Taken:________________

Please Circle Teeth To Be Treated

Right — Left

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

Have you advised the patient of the possibility of extraction of any teeth?

☐ Yes ☐ No if so, which teeth?____________________________

Do you have any restorative plans for treating this case?

☐ Yes ☐ No If so, briefly outline your plans:______________

____

____

____

Special concerns / comments:______________________________

____

____

Would you like a phone call as soon as your patient is seen? ☐ Yes ☐ No

Referring Dr.:____________________________________

Phone:____

White: Periodontist Copy   Yellow: Your Copy