PERIODONTICS / MICROSURGERY / DENTAL IMPLANTS

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Date _____

Introducing _____

Phone _____

X-rays ☐ With patient ☐ Sent in mail/email ☐ To be taken ☐ Not available

Appointment _____ _____
Date Time

Referred by _____

White: Patient / Pink: Patient record / Yellow: Send to periodontist

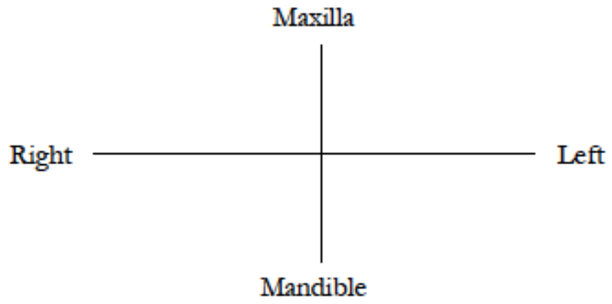
REASON FOR REFERRAL

☐ Complete periodontal evaluation and treatment as indicated
☐ Specific Area _____
☐ Gingival Recession _____
☐ Pathology / Biopsy _____
☐ Emergency Treatment _____
☐ Implant Consultation _____
☐ Other _____

PERIODONTAL TREATMENT COMPLETED IN OUR OFFICE

☐ Plaque control instruction
☐ Prophylaxis and gross scaling
☐ Root planing: Date of service: _____
☐ Periodontal maintenance therapy every __ months for __ years

DENTAL IMPLANTS (please indicate sites)



REMARKS:

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