

## 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

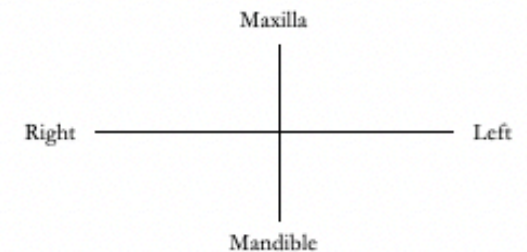
### REASON FOR REFERRAL

- 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_