

PERIODONTAL REFERRAL FORM

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	REFERRED BY (NAME OF DOCTOR)
PHONE	STREET	CITY
STATE	ZIP	E-MAIL ADDRESS

REASON FOR REFERRAL (PLEASE CHECK ALL THAT APPLY):

- | | |
|---|---|
| ☐ Limited periodontal evaluation for _____ | ☐ Gingival contouring for cosmetics |
| ☐ Comprehensive periodontal evaluation | ☐ Dental implants for # _____ |
| ☐ Crown lengthening for # _____ | ☐ Nobel Biocare ☐ Astra Tech ☐ Straumann |
| ☐ Gingival grafting/soft tissue augmentation for # _____ | ☐ Other: _____ |
| ☐ Surgical exposure of teeth for orthodontic purposes | |

FULL MOUTH RADIOGRAPHS (PLEASE CHECK ALL THAT APPLY): ☐ Need to be taken ☐ Mailed ☐ Patient carrying it ☐ E-mailed

PERIODONTAL TREATMENT COMPLETED AT YOUR OFFICE (PLEASE CHECK ALL THAT APPLY):

- ☐ Periodontal maintenance procedure (Date of last PMP: ____/____/____) ☐ Scaling and root planing on _____

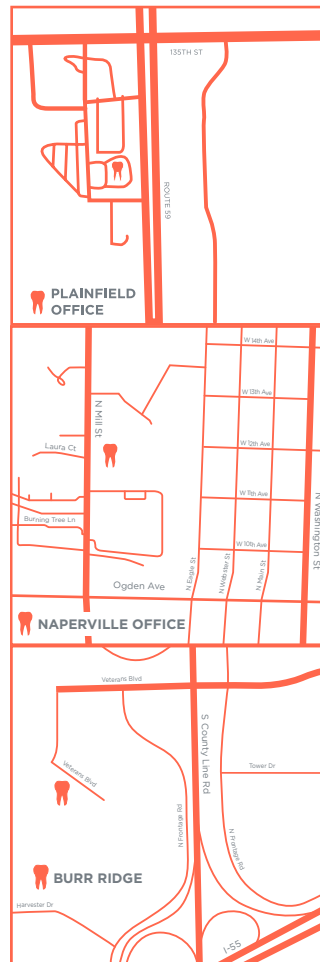
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