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Periodontics • Dental Implants • Oral Plastic Surgery • Sleep Apnea

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Introducing ____

Telephone ____

Referred by Dr.____________________________________ Date______________

Referring patient for:

______ Muco-Gingival Evaluation

______ Complete Periodontal Evaluation

______ Crown Lengthening

______ Dental Implants

______ Sleep Apnea

Areas of special concern: ____________________________________

Recent Full Mouth Radiographs: ☐ Accompany ☐ Mailed ☐ Emailed

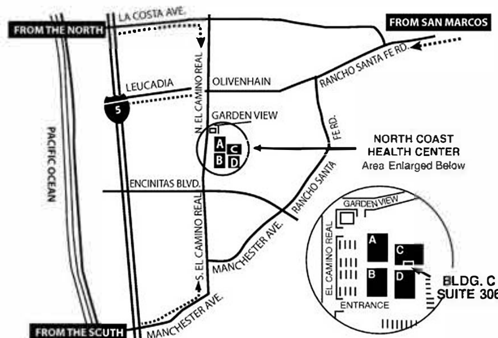
How long has the patient been in your practice?__________________ Other than the patient's current examination on _________________ When was the last date you saw the patient for a dental examination?__________________________________

Patient's level of concern______________________________________

What treatment has he/she had in your office to date?

- ☐ Initial examination and full mouth radiographs. Date of this service __________________
- ☐ Prophylaxis and Gross Scaling
- ☐ Root Planing. Date(s) of service________________ Quadrants:__________________
- ☐ Periodontal Maintenance Therapy every __________ months for ______________years.
- ☐ Extensive Restorative Therapy
- ☐ Other ____

Tentative Restorative Plans ____



APPOINTMENT DATE: ______________________________ TIME:______________

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