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PERIODONTAL REFERRAL

Date: _____ Appointment Date: _____

Patient Name: _____ Phone: _____

Referred by Dr: _____

Please Evaluate:

____ Comprehensive Exam

____ Limited Exam

Teeth #'s _____

Do you have restorative plans?

- Yes No

Please check the following that apply.

Would you like a telephone call during
the patient's appointment?

- Yes No

Mucogingival Problem

Crown Lengthening

Periodontal Abscess

Frenectomy

Other _____

Radiographs:

Enclosed please find all radiographs available from my office.

I have no radiographs. Please take what you will need.

Our office will email radiographs to xray@centralvalleyperio.com

Tentative restorative treatment plans:

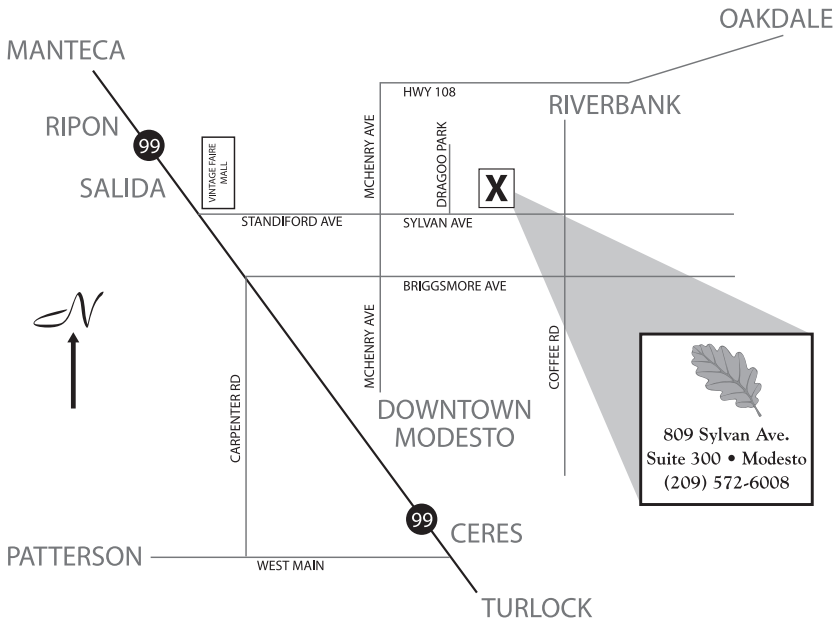
Comments:

Date of last cleaning: _____

Please complete all SRP at your office.

Please refer patient back to our office for SRP.

Signed: Dr. _____




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