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Periodontics • Dental Implants
Oral Medicine
Laser Periodontal Therapy
Board Certified in Periodontology & Dental Implant Surgery

Referred by ______________________________ Date ______________

Is patient to call us? yes no Should we call patient? yes no Contact you by ______________ if unscheduled

Patient name ______________________________

Local mailing address ______________________________ Home #( )______________

Work # ( )______________

What x-rays are you sending that will be helpful to us?

What are your concerns that prompted the referral?

Abscess
Pocket depth
Furcation involvement
Recession
Ridge form/Ridge atrophy
Other
Pain
Problem developing the treatment plan
Mobility
Embrasure space
Tooth position
Tori
NUG/Trench mouth
Undetermined oral lesion
Crown length
Access to margin
Esthetics
Failing restoration/prosthesis

What do you plan to do?

Restorative
Crown
A-splint
Root planing
Full denture
Bridge
Endodontics
Periodontal Maintenance
Alternate Periodontal Maintenance
Partial denture
Orthodontics
Extractions
Other

What would you like me to do? By a specific date? ______________

Emergency treatment only
Treat recession
Crown length surgery
A-splint
Implant(s)
Take x-rays
Reinforce my treatment plan
Develop periodontal-prosthesis treatment plan
Periodontal Maintenance
Treat periodontitis
Other

Incremental treatment (what are priorities?)

Prescription perio/only treat area described

Patient Concerns

appearance cost/insurance missing teeth mobility recession sensitivity time tooth loss treatment pain other

Comments:

Active Member
American Academy of Periodontology

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