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PERIODONTICS AND IMPLANTS

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Introducing: _____ Date _____

Referring Doctor: _____

Reason for referral:

___ Complete periodontal evaluation

___ Limited area evaluation _____

___ Implant consultation _____

___ Crown lengthening _____

___ Mucogingival condition/deficiency _____

___ Sinus floor elevation _____

___ Ridge augmentation _____

___ Extraction & socket preservation _____

___ Cone Beam 3D (CBCT) _____

Remarks:

Procedures performed previously:

___ Scaling & Root Planing UR UL LR LL Date _____

___ Antibiotic therapy Date _____

___ Prep & Temp Date _____

Radiographs sent: ___none ___fmx ___pan ___pa's ___bw's

❑ Please check here if you need more referral pads.

PLEASE FAX A COPY TO 301-972-1822