

# Periodontics Referral Form

Date: \_\_\_\_\_ Referring Dentist/Location: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Patient's Phone: \_\_\_\_\_

				A	B	C	D	E	F	G	H	I	J			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
R				29	28	27	26	25	24	23	22	21	20	19	18	17
				T	S	R	Q	P	O	N	M	L	K			L

## REASON FOR REFERRAL:

- General Evaluation for Periodontal Needs \_\_\_\_\_
- Dental Implants \_\_\_\_\_
- Muco-Gingival Problems \_\_\_\_\_
- Crown Lengthening Procedure \_\_\_\_\_
- Evaluation of Oral Lesion \_\_\_\_\_
- Emergency Periodontal Problem Area \_\_\_\_\_
- Other \_\_\_\_\_

X-rays Being Sent \_\_\_\_\_ BWX \_\_\_\_\_ FMX \_\_\_\_\_

Additional Information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please bring this referral, a current medication list, and dental insurance information to your appointment. Contact our office for instructions on how to complete your registration and medical history prior to your appointment.