Missih Dental Care & Periodontics

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PERIODONTAL REFERRAL FORM

Date: Time:

First Name: Referred By:

Last Name: Phone:

REASON FOR REFERRAL

- ☐ Implants
- ☐ Gingival Recession
- ☐ Graft For Root Coverage
- ☐ Crown Lengthening
- ☐ Guided Tissue Regeneration
- ☐ Gingival Contouring For Cosmetics
- ☐ Ridge Augmentation
- ☐ Other:

RADIOGRAPHS

- ☐ Being Mailed
- ☐ Given to Patient
- ☐ Please Take
- ☐ No X-Ray

IMPLANTS

- ☐ ITI (Straumann)
- ☐ 3i
- ☐ Nobel Biocare
- ☐ Neoss
- ☐ Others:
- ☐ Zimmer
- ☐ SPI (Thommen)
- ☐ Bti
- ☐ OSSTEM

SURGICAL TEMPLATE

- ☐ Provided by Restorative Dentist
- ☐ Provided by Periodontist

PERIODONTAL TREATMENT COMPLETED IN YOUR OFFICE

- ☐ Plaque Control Instruction
- ☐ Prophylaxis and Gross Scaling
- ☐ Root Planing
- ☐ Periodontal Maintenance Therapy

Have you advised the patient of the possibility of extraction of any teeth? If yes, which tooth numbers?

	Right								Left							
1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17

Is there any restorative dentistry that needs to be completed?

COMMENTS:

Thank you for your interest in our services. Please fill out the information above and one of our team members will contact you.