



Advanced Periodontics & IMPLANTOLOGY

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Referring Doctor _____ Date _____

- Patient Information -

Introducing Patient _____

Address _____ Preferred Phone _____

My Patient Requires:

- A periodontal examination and treatment
- An implant and/or sinus graft evaluation and treatment (circle area/teeth)

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

Reason for referral:

The following restorative/prosthetic procedures are planned in the area of periodontal treatment: _____

- We will call to explain the case and restorative needs in more detail.
- Patient requires *antibiotic pre-medication* before appointment.

Previous history of periodontal treatment:

Root planing Surgery Maintenance; Interval _____

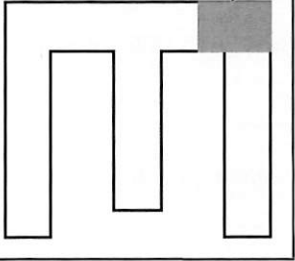
Recent full mouth radiographs are available Yes. We will email mail
Radiographs are required at time of evaluation Please take and send a set.

Your appointment is _____ at _____	AM PM
<input type="checkbox"/> Please call to make an appointment as soon as possible.	

Thank You for your Referral!



E 1st Ave

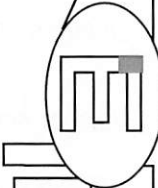


Village Lane

In Motion
Fitness

HWY 99

E 1st Ave



In Motion
Fitness

Longfellow Ave

E 1st Ave

