Advanced Periodontics & IMPLANTOLOGY

Beatrice Criveanu, DDS, MSD
1279 East 1st Ave #D
Chico, CA 95926

referral@apichico.com
Phone: (530) 809-2379
Fax: (530) 924-4599

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

___ Please call to make an appointment as soon as possible.

Thank You for your Referral!