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ORTHODONTICS AND PERIODONTICS

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PERIODONTIC REFERRAL

Introducing _____ Tel.: (H) _____
Tel.: (B) _____
From Dr. _____ Tel.: _____

Time in practice:
- ☐ New patient
- ☐ Active patient
- ☐ Other _____

Patient has had:
- ☐ Recent Scaling: Date: _____
- ☐ Recent Radiographs:
  - ☐ PAs No. or Films Date: _____
  - ☐ Panorex Date: _____

X-Ray Sent:
- ☐ By mail
- ☐ With patient
- ☐ By email _____

Referred for:
- ☐ Complete Periodontal Evaluation
- ☐ Pre Ortho
- ☐ Specific Problem
- ☐ Emergency Treatment for _____

Special Comments: _____

An appointment for an periodontic evaluation has been reserved for: Date: _____ SUBMIT FORM

PLEASE NOTE: If unable to keep this appointment please advise us at least 24 hours before scheduled time. Thank you.