EAST COUNTY PERIODONTICS
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Periodontal Therapy & Dental Implants

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Date:_____

Introducing:_____

Patient Phone:_____

Referred By:_____

Date Referred:_____

Last Treatment in your office was for:_____

_____

_____

Reason For Referral

- ☐ Periodontal Evaluation
- ☐ Bone Grafting
- ☐ Gingival Grafting
- ☐ Implant
- ☐ Emergency Visit
- ☐ Crown Lengthening
- ☐ Root Planing
- ☐ Extraction

Radiographs (Please e-mail)

☐ Given to Patient ☐ Please Take ☐ Being Mailed

☐ Last FMX / PA / BW Radiograph

Date Taken:_____

Please Circle Teeth To Be Treated

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

Have you advised the patient of the possibility of extraction of any teeth?

☐ Yes ☐ No if so, which teeth?_____

Do you have any restorative plans for treating this case?

☐ Yes ☐ No If so, briefly outline your plans:_____

_____

_____

_____

Special concerns / comments:_____

_____

_____

Would you like a phone call as soon as your patient is seen? ☐ Yes ☐ No

Referring Dr.:_____

Phone:_____

White: Periodontist Copy

Yellow: Your Copy