PERIO & IMPLANTS DENTAL GROUP

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Patient Information

Name: _____ Date: _____
Home/Cell#: _____ Email: _____

Does the patient require antibiotic prophylaxis prior to dental treatment? ○ **Yes** ○ **No**

Referring Doctor Information:

Referring Dr. _____
Telephone: _____ Fax _____ Email: _____

I am referring this patient for:

- ○ Complete Periodontal Evaluation & Treatment: _____
- ○ Limited Exam of Localized Areas: _____
- ○ Periodontal Procedure(s): SCRP, Perioscopy, LANAP, Osseous Surgery: _____
- ○ Crown Lengthening (Functional / Esthetic): _____
- ○ Recession / Minimally invasive gum grafting: _____
- ○ Surgical Extraction and Socket Grafting: _____
- ○ Dental Implant(s) Consultation & Treatment: _____
- ○ All-On-4(X) / Implant Supported Overdenture _____
- ○ Sinus Augmentation: _____
- ○ Ridge Augmentation: _____
- ○ Peri-Implantitis Treatments: _____
- ○ Other: _____

Radiographs:

○ FMX ○ BWX ○ PA's ○ Are being forwarded to you ○ If needed, please take

Treatment Discussion:

Please call me: ○ Before examination ○ After examination

Comments or Restorative Plan:

_____
_____
_____
_____

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