KING ST. DENTAL
DENTAL WELLNESS CENTER

Periodontal Referral

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Introducing

Name: ______________________ Phone: ______________

E-mail: ______________________

Your Concerns

☐ General Periodontal Assessment
☐ Specific Area(s): ______________________

Regarding:

☐ Emergency/Abscess
☐ Recession Grafting
☐ Esthetic Recontouring
☐ Frenectomy
☐ Deep Pockets
☐ Crown-Lengthening
☐ Canine Exposure
☐ Ortho Implant
☐ Pathology/Biopsy
☐ Implant Consult
☐ Bone Graft
☐ Sinus Lift
☐ Mucogingival Defect
☐ Extraction Grafting

Additional Info:
____
____

Radiographs: ☐ Regular mail ☐ E-mail ☐ Given to patient ☐ Take & send me copies

Restorative: ☐ Completed / non pending ☐ Waiting on perio

Prosthodontic objectives: ______________________
____

Patient's Concerns: ☐ Esthetics ☐ Mobility ☐ Effect on health ☐ Discomfort ☐ Tooth loss ☐ Anxiety ☐ Finances ☐ Function ☐ Other: ______________

Referring Doctor's Information

Name: ______________________

Hygiene: ☐ I recommend an alternating hygiene schedule for this patient
☐ I prefer to continue performing all hygiene at my office

Notes:

☐ Send more referral slips ☐ I want to observe the procedure ☐ Call when the patient is in

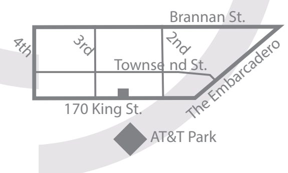
☐ Other: ______________________

Appointment Request

☐ Please call patient ☐ Patient will call

☐ Scheduled for: ______________ (date) at: ______________ (time)

Patient Checklist: ☐ New Patient Form ☐ X-rays ☐ This Referral Form ☐ Insurance Info



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