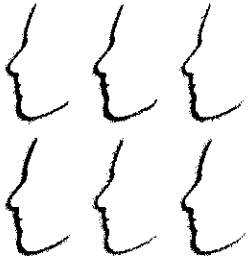

PERIODONTAL
ASSOCIATES

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A Professional Dental Team Emphasizing
Preventative Periodontics, Implants and Wellness

Patient Name:	Date:

I have referred the above patient to you for the following:

☐ Complete periodontal evaluation & treatment

☐ Suspected isolated area(s) of destruction: _____

☐ Crown lengthening of tooth No.(s): _____

☐ Gingival grafting / root coverage: _____

☐ Implant consultation: _____

Periodontal therapy performed:

☐ None

☐ Scaling and Root Planing: Month: _____ Year: _____

Radiographs:

☐ Full mouth series taken within the last year enclosed

☐ Take the necessary x-rays & send a duplicate set for my records

Please contact me:

☐ Prior to the examination ☐ By Phone

☐ After the examination ☐ By E-mail ☐ Only if needed

Referring Doctor:

Comments / Specific Restorative Plans: