PINOLE
Periodontics & Dental Implants

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Patient _____ Date: _____

Patient Phone: _____

Patient Doctor: _____

Patient is being referred for:

_____ Comprehensive Periodontal Examination
_____ Implant evaluation for areas: _____
_____ Limited Periodontal Consult (area of concern is _____)
_____ Horizontal/ Vertical bone loss
_____ Tissue Recession (tooth/teeth #'s) _____
_____ Minimal/ No attached gingiva
_____ Crown Lengthening _____

Pertinent Patient History:

New Patient _____ Patient since _____
Maintenance Interval: _____ Months
Patient Compliance _____Good _____Sporadic
Date of last maintenance visit: _____ Last FMX _____ BWX _____
How many exams has patient had this year? _____ Date(s) _____
Quadrant Root Planing Completed. Date _____UR _____UL _____
LR _____LL _____

Radiographs

Will be forwarded to office before appointment. Digital _____, Film _____
Unavailable / Out of date _____ Please take _____

Do you have any restorative plans for this patient at this time?

_____

Please call _____ Before consultation appointment _____After consultation _____ No call needed

Additional Information/Special Instructions

_____

_____

Thank you for your referral