Referring Doctor's Information

Referring Doctor's Name:

Street Address:

City: | State: | Zip:

Office Phone Number:

Your Comments:

Patient Information

Name: | Phone Number:

What is the appointment status of this patient?

- ☐ Appointment Scheduled
- ☐ Contact Patient to Schedule Appointment
- ☐ Patient Will Contact The Office To Schedule

If scheduled, what date is their appointment? ____ / ____ / ____
month Day Year

Please evaluate this patient for:

- ☐ Pocketing
- ☐ Bone Loss
- ☐ Gingival Recession / Mucogingival Defect
- ☐ Gingival Bleeding / Hyperplasia
- ☐ Tooth Mobility / Drifting
- ☐ Crown Lengthening
- ☐ Dental Implants
- ☐ Gummy Smile / Short Teeth
- ☐ Frenectomy / Fiberotomy
- ☐ Extraction with Ridge Preservation
- ☐ Ridge Augmentation
- ☐ Oral Pathology / Biopsy
- ☐ Other: _____

Area of Concern:

Initial Periodontal Therapy Completed?

What Are Your Restorative Plans?