

Periodontics Referral Form

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This form is to introduce _____.

Please check the reason for referral.

	Full Mouth	Localized Area	Tooth or Teeth #
Periodontal Consultation			
Implant Consultation			
Deep Scaling & Root Planing			
Crown Lengthening			
Periodontal Surgery: Osseous, Mucogingival, Bone Grafting			
Gingivectomy			
Recession Coverage			
Crown Exposure			
Fibrotomy, Frenectomy			
Ridge Augmentation, Alveoplasty, Tuberosity Reduction			
Tori Removal			
Hemisection			
Root Amputation			
Retrofill, Apicoectomy			
Biopsy, Pyogenic Granuloma Removal			

Additional Comments: _____

Recent Radiographs:

- Unavailable Please Take New Radiographs
- Accompanying Patient
- Mailed To Your Office

Referred By Dr. _____ Date: ____ / ____ / ____

To Clairemont Office OR Rancho Bernardo

Address: _____ Phone: _____