

Phone: 770-740-0442

Fax: 770-740-9830

Date of referral: _____ / _____ / _____
(Month) (Day) (Year)

Referring Doctor: _____ General Practitioner: _____
(If different from referral doctor)

Dr. Office Phone Number: _____

Introducing: Mr. Ms. Mrs. Dr. _____
(Last) (First) (M.I.) (Preferred Name)

Home#: _____ Work#: _____ Cell#: _____

- Please Evaluate:**
- | | | |
|---|---|--|
| <input type="checkbox"/> Periodontal Condition | <input type="checkbox"/> Gingival Graft | <input type="checkbox"/> Frenulectomy and Fiberotomy |
| <input type="checkbox"/> Osseointegrated Implant Therapy | <input type="checkbox"/> Root Coverage Grafting | <input type="checkbox"/> Periodontal Maintenance Care |
| <input type="checkbox"/> Crown Lengthening, Tooth # _____ | <input type="checkbox"/> Recession | <input type="checkbox"/> Impacted Tooth Exposure |
| <input type="checkbox"/> Cosmetic Gingival Recontouring | <input type="checkbox"/> Periodontal Abscess | <input type="checkbox"/> Endodontic/Periapical Surgery |
| | | <input type="checkbox"/> Biopsy |

Special Problem Areas Limited To:

R	1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16	L
	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17	

Other

PLEASE CONTACT PATIENT TO SCHEDULE AN EXAMINATION APPOINTMENT.

Appointment* Date: _____ / _____ / _____ Time: _____ A.M. _____ P.M.
(Month) (Day) (Year)

*If unable to honor appointment please give courtesy of 48 hours notice: (770) 740-0442
 If you have dental insurance, be sure to bring your insurance card with you.

PLEASE PROVIDE THE FOLLOWING PERIODONTAL REFERRAL INFORMATION

Radiographs taken in the last 3 years: _____ PAN _____ FMX _____ PA _____ BW _____

Being sent with patient _____ Being mailed to us _____ Being emailed to us _____

Last Prophylaxis: _____ Last Scale/Root Planing _____

Major Restorative Treatment Planned/Completed:

Any Other Information: