PERIODONTAL REFERRAL FORM

Date: _____
Patient's Name: _____ Phone: _____
Referring Doctor: _____ Phone: _____

REASON FOR REFERRAL: (select all that apply)

Appointment Date: _____
Time: _____

☐ Comprehensive/Full Mouth Periodontal Exam
☐ Limited Periodontal Exam, area(s): _____
☐ Scaling and Root Planing
☐ Crown Lengthening, area(s): _____
☐ Dental Implant/Extraction with Socket Preservation, area(s): _____
Abutment to be placed by: ☐ surgical dentist or ☐ restorative dentist
☐ Frenectomy and/or Fiberotomy, area(s): _____
☐ Exposure of Impacted Teeth (canines), area(s): _____
☐ Gingival Recontouring, area(s): _____
☐ Periodontal Surgery, area(s): _____
☐ Recession, Soft Tissue Grafting (graft for root coverage), area(s): _____
☐ Other(s): _____

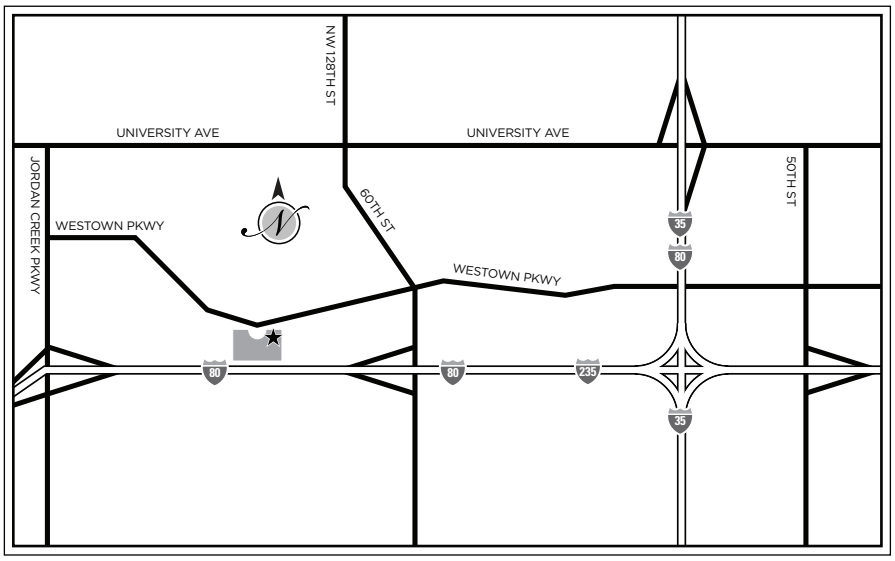
RADIOGRAPHS:

☐ need to be taken
☐ mailed
☐ patient will bring
☐ e-mailed (xray@parkwaypg.com)

PERIODONTAL TREATMENT COMPLETED IN YOUR OFFICE:

☐ plaque control instructions
☐ scaling and root planing, when: _____
☐ prophylaxis and/or gross debridement
☐ periodontal maintenance therapy

COMMENTS:



Please enter on northeast side of the building. We have our own entrance below the Parkway Periodontal Group sign.

Dr. Julie K. Statz
Dr. Thomas A. Statz
Dr. Brandon K. Peterson

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