thepracticesf
PERIODONTAL HEALTHCARE AND IMPLANT DENTISTRY

Patient's name _____

Patient's phone number _____

Date referred _____

Patient is being referred for:

- ☐ Complete periodontal evaluation.
- ☐ Limited periodontal evaluation. Reason for limited evaluation:
  - ☐ Only area of involvement is: _____
  - ☐ Patient is not interested in complete treatment at this time.
  - ☐ Other _____
- ☐ Gingival recession (circle tooth number(s) below).
- ☐ Crown lengthening for tooth # _____
- ☐ Implant evaluation for areas: _____

Areas of special concern:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

R _____ L

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

How long has the patient been in your practice? _____

When did you last see the patient for a dental examination? _____

What treatment has the patient had in your office to date?:

- ☐ Full mouth radiographs. Date: _____
- ☐ Plaque control instruction.
- ☐ Prophylaxis and scaling. Date: _____
- ☐ Root planing. Date: _____ UR _____ LR _____ UL _____ LL _____
- ☐ Supportive periodontal treatment (maintenance):
  Every _____ months for _____ years.
  Date of last visit: _____ Date of next visit: _____
- ☐ Equilibration/TMJ therapy.
- ☐ Extensive restorative therapy.
- ☐ Other _____

Have you advised the patient of the possibility of extraction of any teeth?

☐ Yes ☐ No If so, which teeth? _____

Do you have any restorative plans for treating this case at this time?

☐ Yes ☐ No If so, briefly outline your plans.

Remarks:

Thank you. Referring Dr. _____

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