PERIODONTICS NORTHWEST

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☐ No Preference

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Date:______________________

Introducing: ____

____
Address
____
City
____
Telephone (Residence) (Business)

Referred By: ____

Reason for Referral: ____

☐ Complete Periodontal Exam
☐ Limited Periodontal Exam
☐ Mucogingival Problem
☐ Crown Lengthening
☐ Oral Pathology
☐ Restorative Consultation
☐ Emergency
☐ Other (specify)______________________________
☐ Implants

Comments: ____

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Radiographs:

☐ Are needed. And remit copy.
☐ Are enclosed. Please return after treatment.
☐ Accompanying patient.
☐ Please coordinate X-rays for implant exam.

Appointment:

An appointment has been scheduled for__________ at ________________

☐ Please contact our patient and schedule an appointment.
☐ Our patient was advised to call your office for an appointment. If the patient does not call within 2 weeks, please contact them to schedule an appointment.

Treatment provided by our office:

☐ Long term maintenance patient ☐ New patient to our office
☐ Prophy performed: Date:____________
☐ SRP performed: Date:____________

Treatment Coordination:

☐ The following treatment has been presented to my patient.
Please reinforce. ____
☐ Please telephone my office prior to your examination.
☐ I would like to do my own:

Extractions_____ Endo ______ SRP_____
Bite Adjustment_____ Orth______

Thank you for your kind referral!