PERIODONTAL REFERRAL FORM

Patient Name: _____ Phone No: _____
Referring Doctor Name: _____ Phone No: _____
Address: _____

Reason for Referral

- ☐ Periodontal Evaluation Only
- ☐ Bone Graft
- ☐ Implant
- ☐ Osseous Surgery
- ☐ Crown Lengthening
- ☐ Gingivectomy
- ☐ Tissue Grafts
- ☐ Frenectomy
- ☐ Emergency Evaluation (problem focused)
- ☐ Other

Tooth #(s) _____ Quads: _____

Has the patient had previous periodontal therapy?

- ☐ None
- ☐ Prophylaxis Only
- ☐ Antimicrobial Therapy
- ☐ Scaling and Root Planning
- ☐ Surgery

Have you advised the patient of the possibility of extraction of any teeth? Yes ☐ No ☐

If yes which teeth? _____
_____

Does the patient require premedication? Yes ☐ No ☐

Antibiotic used: _____

Radiographs:

☐ Please take/send copy ☐ Patient will bring copy ☐ I will send / Please return
☐ Emailed info@largodentalone.com

Your Restorative Plans

_____
_____

Comments:_____
_____
_____

Please

- ☐ Call me before seeing the patient
- ☐ Call me after seeing the patient
- ☐ Alternate recare appointments
- ☐ Do all recare

General Dentist signature: _____ **Date:** _____

Dr Gabriela Vila, D.M.D., M.S.

LOCATION
Largo Dental One
1475 Belcher Road S, Largo, FL, 33771

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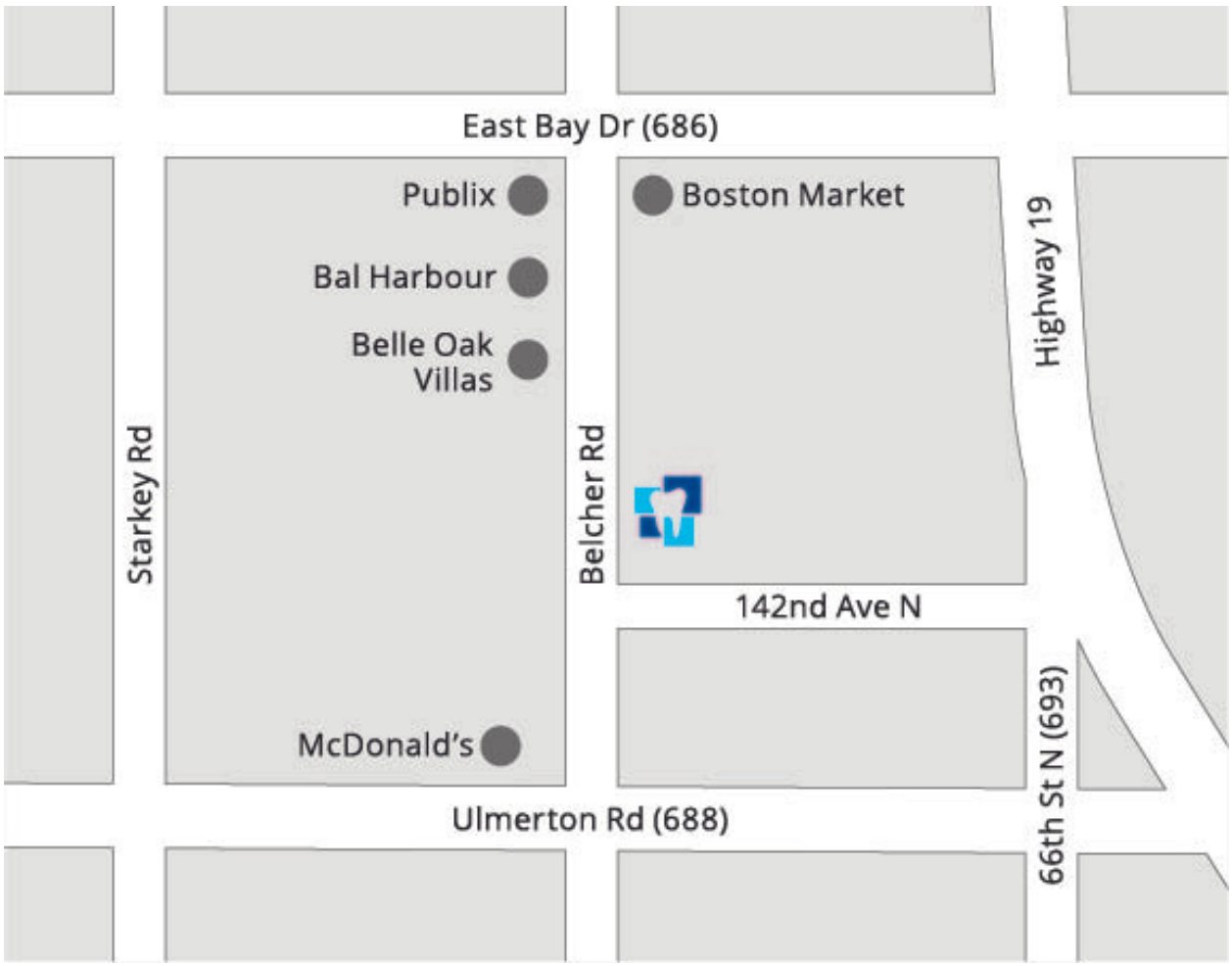

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