

PERIODONTAL CONSULTATION REFERRAL

Referred by: _____

Introducing: _____ Tel. #: _____

Appointment date: _____ Time: _____

Do they need Pre-Med? Yes No

Periodontal therapy in your office to date: _____

I am sending: Full mouth survey Panoramic radiograph

Bite wings No current radiographs available

Comments: _____

- Periodontal Disease
 - Full Exam
 - Isolated teeth (indicate on chart below)
- Bone Regeneration - Ridge Augmentation
- Crown Lengthening (Anterior for Esthetics)
- Crown Lengthening (Posterior for Function)
- Esthetic Gingival Contouring
- Dental Implant
- Biopsy
- Orthodontic Tooth Exposure
- Frenectomy
- Soft Tissue Graft
- Other _____

AREAS OF CONCERN:

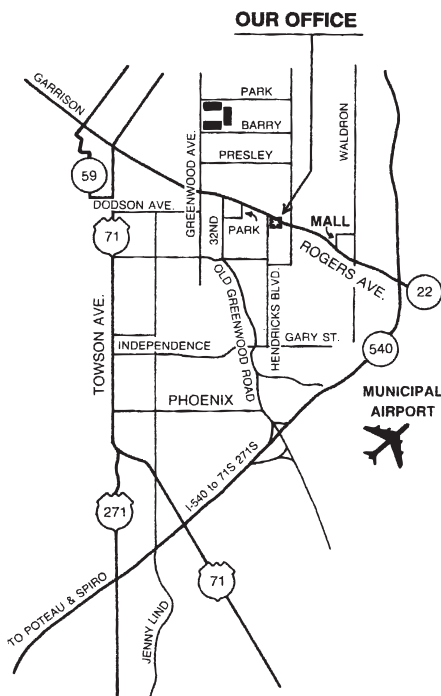
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

The restorative treatment plan may include:

- Operative
- Implants
- Partial Dentures
- Dentures
- Crown and Bridge
- Occlusal Therapy
- Maxillary
- Mandibular
- Maxillary
- Mandibular

Comments: _____

Thank you for entrusting us with the care of your patient!



FORT SMITH OFFICE:

3800 Rogers Ave, Suite 3
Fort Smith, Arkansas 72903
phone: 479-785-4848
fax: 479-785-0231