Steven L. Wilson, DDS, LLC
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Periodontal Referral Form

PATIENT INFORMATION:

First Name_____ Date of Birth _____

Last Name_____

Phone_____ E-Mail_____

❒ Patient will call for appointment ❒ Please call patient

REFERRED FOR THE FOLLOWING:

❒ **Complete Periodontal Evaluation:** ❒ **Early** ❒ **Moderate** ❒ **Advanced**

❒ Implants
❒ Gingival Recession
❒ Graft for Root Coverage
❒ Crown Lengthening
Teeth # _____
❒ Guided Tissue Regeneration
Teeth #_____
❒ Gingival Contouring for Cosmetics
Teeth # _____
❒ Ridge Augmentation

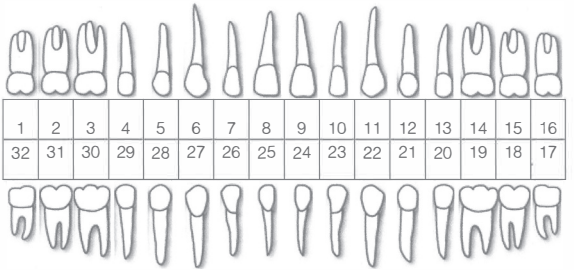
Treatment_____

_____

POSSIBLE EXTRACTIONS:

Have you advised the patient of the possibility of extraction? If so, which tooth number(s)_____

_____



RADIOGRAPHS OR CLINICAL PHOTOS: (with dates)

❒ Being Mailed
❒ Being Emailed
❒ Given To Patient
❒ No X-Ray, Please Take

PERIODONTAL TREATMENT COMPLETED IN YOUR OFFICE:

❒ Plaque Control Instructions
❒ Root Planing
❒ Prophylaxis and Gross Scaling
❒ Periodontal Maintenance Therapy

REFERRING DOCTOR:

Name_____Phone_____