PIONEER PERIODONTICS & IMPLANT DENTISTRY, PC

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# PATIENT REFERRAL FORM

Date: _____

Referring Doctor: _____ Address: _____

Phone: _____ Fax: _____ E-Mail: _____

Patient's Name: _____ Address: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

____ Please call patient for appointment ____ Patient will call for appointment

____ Radiographs to be mailed/emailed ____ No radiographs

## MY FINDINGS INDICATE A NEED FOR:

____ Implant evaluation

____ Regular periodontal evaluation including: pocket depths, mucogingival evaluation, furcations, mobility, periodontal radiographs, plaque control analysis, etc.

____ Limited periodontal evaluation for gingival recession, gingival graft, isolated area of pocketing, root amputation, crown lengthening procedure, bone graft.

____ Please specify other problem: _____

_____

## PLANNED RESTORATIVE CARE AND COMMENTS:

Possible extractions: X
Possible implants: I
Questionable teeth: ?
Missing teeth: M
Problem areas: Circle

_____

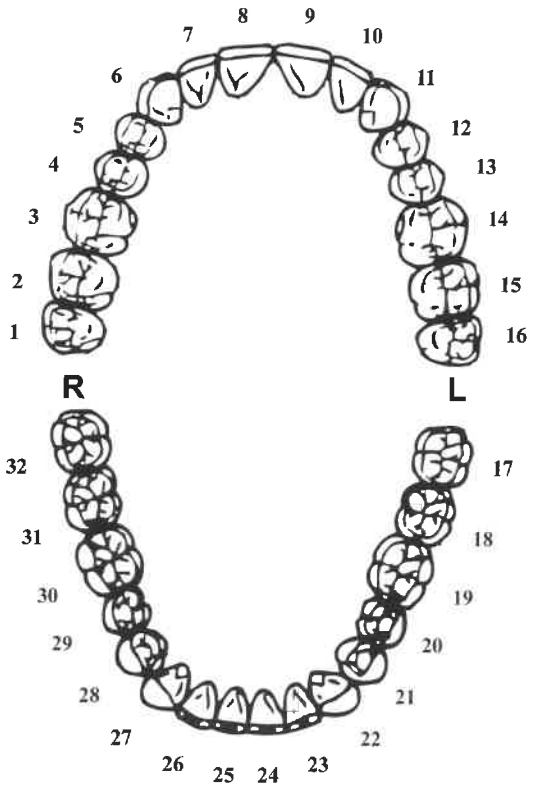
_____

_____

_____

_____

_____

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