Evaluation and Treatment Request for Implant and Periodontal Surgery

Referring Doctor's Information (Name, Office):		☐ Please call patient
		☐ Patient will call
Office Phone ____ - ____ - _______	Office Fax ____ - ____ - _______	☐ Patient has appointment

Patient Contact Information

		___ / ___ / ______	Contact Number(s)
(First)	(Last)	(Date of Birth)	___ - ___ - _______
Special Considerations:			___ - ___ - _______
☐ Patient needs pre-med	☐ Patient desires sedation	☐ Patient is in pain, schedule soonest available	

Site to be Treated

☐ Tooth Number(s) or Quadrant:

_______________ ☐ UR ☐ UL ☐ LR ☐ LL

☐ Comprehensive Periodontal Evaluation for:

☐ Mild
☐ Moderate Periodontitis
☐ Severe

Additional Comments:

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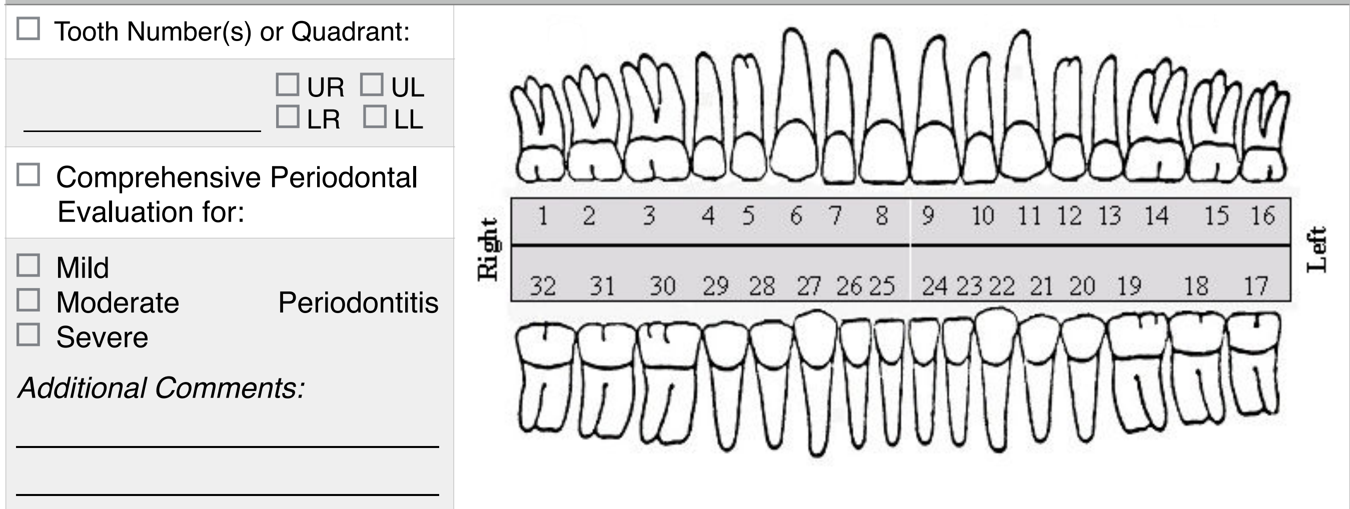

Referral Request

Implant Surgery	**Gingival Surgery**	**Periodontal Surgery**	**Oral Surgery**
☐ Implant Consultation	☐ Esthetic Crown Lengthening	☐ Osseous Surgery or Flap Debridement	☐ Tooth Extraction
☐ Implant Placement	☐ Increase Tissue Width, Free Gingival Graft	☐ Bone Grafting	☐ Impacted Canine Exposure
☐ Sinus Augmentation	☐ Tooth Root Coverage	☐ Crown Lengthening	☐ Biopsy

Additional Comments or Special Instructions:

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