Periodontal Associates
The Dental Implant Team

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Excellence in Dental Implants & Periodontics

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Date: _____

This is to Introduce

Patient's Name: _____

Patient's Telephone: _____

Patient's Address: _____
Street City Zip

Referred by Dr. _____

Telephone: _____

☐ **Appointment Date** _____

☐ **Please call patient to schedule appointment** ☐ **Patient will call to schedule**

Is antibiotic premedication needed? ☐ **Yes** ☐ **No**

Reason for referral:
- ☐ Implant Evaluation _____
- ☐ Complete Perio. Exam _____
- ☐ Limited Perio. Exam _____
- ☐ Recession _____
- ☐ Crown Lengthening _____
- ☐ Esthetic Procedure _____
- ☐ Other _____

Please indicate particular areas of concern, restoration plan, implant or esthetic areas, etc.

_____

_____

_____

Radiographs: ☐ Please take & send copy

Films Available: ☐ Full mouth ☐ Limited ☐ Panoramic

Being Sent: ☐ By mail ☐ By Email ☐ With patient

Please call me: ☐ Before Seeing Patient ☐ After Seeing Patient

Please detach and give top copy to patient.
Please email referral to littleton@theperiodocs.com.