PERIODONTAL & IMPLANT CLINIC

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PERIODONTAL & IMPLANT REFERRAL

Tel: 250 754 1233 Fax: 250 754 1236 email: petricca.reception@shaw.ca

WE ARE REFERRING: **DATE:** ____________

Patient: ____________ D.O.B.: MM / DD / YY

Address: ____________ Postal Code: ____________

Telephone / Home: ____________ Cell: ____________ Business: ____________

Significant Medical History Findings: ____________

REASONS FOR REFERRAL:

- ☐ Full Mouth Periodontal Evaluation
- ☐ Localized Evaluation # (s) ____________
- ☐ Esthetic Evaluation Area: ____________
- ☐ Crown Lengthening # (s) ____________
- ☐ Ridge Augmentation Area: ____________
- ☐ Soft Tissue Grafting # (s) ____________
- ☐ Implant Evaluation Area: ____________

REMARKS OR SPECIAL INSTRUCTIONS

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PERIODONTAL TREATMENT COMPLETED TO DATE

☐ Scaling ☐ Root Planing ☐ Surgery Type:

RADIOGRAPHS: ☐ Sending radiographs ☐ No recent radiographs

PERIODONTAL PROBINGS: ☐ Sending probings ☐ No recent probings

INSURANCE INFORMATION:

Insurance Co.: ____________ I.D.#: ____________

Employer: ____________ Group #: ____________

Note: we do not take assignment for insurance, however, we will assist you in filling out your insurance form(s)

REFERRING DENTIST: ____________ Signature ____________

REFERRING HYGENIST: ____________

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Address: #503 - 495 Dunsmuir Street, Nanaimo, BC V9R 6B9 - Tel: 250 754 1233
Refer to website for satellite locations www.petriccaperio.com

WHITE: Periodontist YELLOW: Patient PINK: Referring Dentist