Dr. Giorgio Petricca
Certified Specialist • Periodontics & Implants

Dr. Giorgio M Petricca Inc.
BSc., MSc., DMD, Dip. Perio., MSc., FRCD(C)

www.PetriccaPerio.com

PERIODONTAL & IMPLANT REFERRAL

Tel: 1 (778) 406-1077 **Email: petriccam@shaw.ca**

WE ARE REFERRING: **DATE:** ____________________

Patient: ______________________________ Birthdate: MM / DD / YY

Address: ______________________________ Postal Code: __________

Home Tel: __________ Cell: __________ Work: __________

Significant Medical History Findings: ______________________________

REASONS FOR REFERRAL:

- ☐ Full Mouth Periodontal Evaluation
- ☐ Localized Evaluation # (s) __________
- ☐ Esthetic Evaluation Area: __________
- ☐ Crown Lengthening # (s) __________
- ☐ Implant Evaluation Area: __________
- ☐ Soft Tissue Grafting # (s) __________
- ☐ Socket Preservation (GBR): __________
- ☐ Extraction # (s) __________

REMARKS OR SPECIAL INSTRUCTIONS ______________________________

____

____

____

PERIODONTAL TREATMENT COMPLETED TO DATE

☐ Scaling ☐ Root Planing ☐ Surgery Type:

RADIOGRAPHS: ☐ Emailing ☐ 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: ______________________________ Tel: __________

Address: #105 - 324 Goldstream Ave, Victoria, BC V9V 2W3 • Tel: 1 (778) 406-1077
Refer to website for satellite locations www.PetriccaPerio.com