



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: **D** **M** **Y**

Address: _____ Postal Code: _____

Home Tel: _____ Cell: _____ Work: _____

Significant Medical History Findings: _____

REASONS FOR REFERRAL:

- | | |
|--|---|
| <input type="checkbox"/> Full Mouth Periodontal Evaluation | <input type="checkbox"/> Localized Evaluation # (s) _____ |
| <input type="checkbox"/> Esthetic Evaluation Area: _____ | <input type="checkbox"/> Crown Lengthening # (s) _____ |
| <input type="checkbox"/> Implant Evaluation Area: _____ | <input type="checkbox"/> Soft Tissue Grafting # (s) _____ |
| <input type="checkbox"/> Socket Preservation (GBR): _____ | <input type="checkbox"/> 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