

PERIODONTAL & IMPLANT REFERRAL

Tel: 250 754 1233

email: petricca.reception@shaw.ca

WE ARE REFERRING:

DATE: _____

Patient: _____ D.O.B.: D/ M/ Y/

Address: _____ Postal Code: _____

Telephone/Home: _____ Cell: _____ Business: _____

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"/> Ridge Augmentation Area: _____ | <input type="checkbox"/> Soft Tissue Grafting # (s) _____ |
| <input type="checkbox"/> Implant Evaluation Area: _____ | |

REMARKS OR SPECIAL INSTRUCTIONS _____

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 HYGIENIST: _____