PERIODONTAL & IMPLANT CLINIC

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PERIODONTAL & IMPLANT REFERRAL

Tel: 250 754 1233 **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 _____

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: _____