Proactive Periodontics
PERIODONTICS & DENTAL IMPLANTS

PERIODONTAL REFERRAL FORM

Dr. Mandy Nematollahi
Certified Specialist in Periodontics

PATIENT'S NAME: _____ Birth Date: _____

Address: _____

City: _____ Postal Code: _____

Tel #: _____ Alternate Tel#: _____

Email: _____

Insurance Company: _____ Group #: _____ ID #: _____

REFERRED FOR:

❑ Comprehensive Periodontal Examination and Treatment.

❑ Specific Examination and Treatment of Areas: _____

_____

❑ Implant(s) w/Healing Abutment
❑ Crown Lengthening
❑ Frenectomy
❑ Sinus Augmentation
❑ Pocket Reduction Therapy
❑ Bone Grafting
❑ Soft Tissue Graft
❑ Other _____
❑ Extraction
❑ Surgical Exposure

SPECIAL CONSIDERATIONS:

_____

_____

_____

Radiographs: ❑ Sent via MTS ❑ Emailed ❑ Not Available

REFERRING DOCTOR: _____ Phone: _____

Email: _____

OR: Referring Practice Stamp (if available)

Proactive Periodontics

Please email a copy of this referral to our office at burnaby@proactiveperiodontics.com and give a copy to your patient.

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