Proactive Periodontics

PERIODONTICS & DENTAL IMPLANTS

PERIODONTAL REFERRAL FORM

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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: ________________________

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

SPECIAL CONSIDERATIONS:

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Radiographs: ❑ Sent via MTS ❑ Emailed ❑ Not Available

REFERRING DOCTOR: ______________________ Phone: ______________

Email: ______________________________

OR: Referring Practice Stamp (if available)

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

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