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THIS IS TO INTRODUCE_____ DATE:_____

PHONE #: Hm._____ Wk:_____

WHO IS BEING REFERRED TO YOUR OFFICE FOR:

- ❑ COMPREHENSIVE EXAMINATION
- ❑ LIMITED EXAM OF FOLLOWING AREAS:_____
- ❑ OTHER:_____

FOR THE FOLLOWING CONDITION:

- ❑ GENERALIZED PERIODONTAL DISEASE
- ❑ LOCALIZED PERIODONTAL PROBLEM:_____
- ❑ MUCOGINGIVAL DEFECT:_____
- ❑ IMPLANT CONSULTATION:_____
- ❑ CROWN LENGTHENING (FUNCTIONAL/AESTHETIC)
- ❑ ACUTE PERIODONTAL ABSCESS
- ❑ OTHER:_____

I AM SENDING THE FOLLOWING: ❑ BY MAIL ❑ WITH PATIENT

- ❑ FULL MOUTH SERIES
- ❑ BITE WING RADIOGRAPHS
- ❑ PERIAPICAL RADIOGRAPHS
- ❑ PANORAMIC RADIOGRAPH
- ❑ PLEASE TAKE: _____

❑ MEDICAL CONSULTATION NEEDED

SPECIFIC RESTORATIVE PLANS:_____

_____

COMMENTS:_____

_____

FROM DR.:_____ OFFICE#:_____

EMAIL:_____ DATE:_____