DENTAL SPECIALTY CENTER
FALCON

PERIODONTAL REFERRAL

Patient Name: _____

Phone: _____ Email: _____

Referring Dr: _____ Office: _____

☐ Please contact patient ☐ Patient was instructed to contact your office

REASON FOR REFERRAL:

☐ Periodontal Evaluation
☐ Gingival Grafting/Contouring
☐ Crown Lengthening
☐ Bone Graft/ Ridge Augmentation
☐ Evaluate for Osseous Surgery
☐ Evaluate Implant
☐ Other_____

☐ Extraction
☐ Biopsy/Pathology
☐ Sinus Lift
☐ Eval Soft Tissue Grafting
☐ Wisdom Teeth
☐ Expose & Bond # _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
R			A	B	C	D	E	F	G	H	I	J			L
			T	S	R	Q	P	O	N	M	L	K			
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

ANESTHESIA & SEDATION:

Patient would prefer to have procedure(s) performed with:

☐ Oral Sedation
☐ Nitrous oxide
☐ No sedation, Local anesthetic only
☐ Sedation was not discussed

READINESS:

☐ Wants to have treatment done ASAP
☐ Interested in treatment, but not in a hurry
☐ Unsure about treatment, needs more info

RADIOGRAPHS:

☐ Please take radiographs as needed ☐ Will send by email

SPECIAL INSTRUCTIONS:

_____

Please email records to: _____

REFERRING DOCTOR SIGNATURE: _____

_____