RESTORE
PERIODONTICS & IMPLANTS

Jordan Dempsey DDS

PERIODONTAL REFERRAL FORM

Appointment Date	Time

Date _____

Patient's Name _____ Phone _____

Referring Doctor _____ Phone _____

Reason for Referral (select all that apply)

- ☐ Comprehensive/ Full mouth Periodontal Exam
- ☐ Scaling and Root Planing _____
- ☐ Crown Lengthening, area(s) _____
- ☐ Dental Implant/ Extraction with Socket Preservation, area(s) _____
- ☐ Frenectomy, area(s) _____
- ☐ Exposure of Impacted Teeth, area(s) _____
- ☐ Periodontal Surgery, area(s) _____
- ☐ Recession, Soft tissue Grafting, area(s) _____
- ☐ Other _____

Periodontal Treatment Plan

- ☐ Plaque Control Instruction
- ☐ Scaling and Root Planing, when _____
- ☐ Discussion about Periodontal Disease and Etiology
- ☐ Prophylaxis and/ or Gross Debridement
- ☐ Periodontal Maintenance Therapy

Radiographs

Please email all radiographs, including FMX, BWX and area specific Pas taken within the last two year to records@restoreperio.com

Comments

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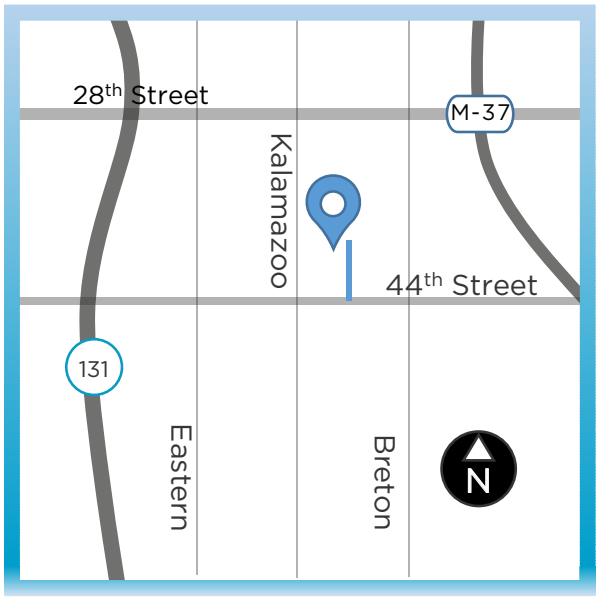

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