WELL-BEING
PERIODONTICS

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Patient Name: _____ **Date:** _____
Last *First* *Middle Initial*

Patient Phone: _____

Appointment: _____ **Time:** _____ **A.M./ P.M.**

Patient is being referred for the following:

- ☐ Complete Periodontal Evaluation _____
- ☐ Recession/ Soft Tissue Grafting _____
- ☐ Gingivectomy/ Crown Lengthening _____
- ☐ Dental Implants, bone grafting, sinus augmentation _____
- ☐ Tooth exposure, TAD placement _____
- ☐ Frenectomy _____
- ☐ Other _____

Radiographs

- ☐ Accompanying patient
- ☐ Mailed to your office
- ☐ Sent by email
- ☐ New radiographs needed

Referred by: _____ **Referred Phone:** _____