J. Marc Haney, D.D.S, M.S. and Matthew Comfort, D.M.D

Periodontal Referral Form

Patient Name: _____ Phone Number: _____

Referring Doctor Name: _____ Phone Number: _____

Referring Doctor Practice: _____

Reason for Referral:

☐ Comprehensive Periodontal Exam – Area(s) of concern: _____

☐ Periodontal Disease Treatment

Area(s) of concern: _____

Has the patient recently had scaling and root planing at your office? _____

If so, approximately when were the scaling and root planings completed? _____

☐ Extraction – tooth #(s): _____

☐ Bone Graft – Site(s): _____

☐ Implant – Site(s): _____

☐ Gingival Graft – tooth #(s): _____

☐ Crown-Lengthening – tooth #(s): _____

☐ Sinus Augmentation – Site(s): _____

☐ Other: _____

Your Restorative Plans:

_____

_____

Periodontal Maintenance Plan:

☐ Patient to return to referring doctor's office for all periodontal maintenance appointments

☐ Alternating periodontal maintenance appointments

☐ Patient to receive all periodontal maintenance at periodontal office

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