



*Matthew Comfort, D.M.D and Y. Priscilla Young D.D.S*  
(626) 966-5622

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 SRPs at your office? \_\_\_\_\_

If so, approximately when were the SRPs completed? \_\_\_\_\_

Extraction – tooth #(s): \_\_\_\_\_

Bone Graft – Site(s): \_\_\_\_\_

Implant – Site(s): \_\_\_\_\_

System Preference:  Straumann  Nobel  SDS (Zirconia)

Gingival Graft – tooth #(s): \_\_\_\_\_

Crown-Lengthening – tooth #(s): \_\_\_\_\_

Sinus Augmentation – Site(s): \_\_\_\_\_

Other: \_\_\_\_\_

**Your Restorative Plans:** \_\_\_\_\_

**Refer To:**

First Available

Dr. Young

Dr. Comfort



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