



*Matthew Comfort, D.M.D, Priscilla Young D.D.S and
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(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. Akin

☐ Dr. Comfort



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