



*Synergy Periodontics  
& Implants*

PERSONALIZED CARE • OUTSTANDING RESULTS

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## REFERRAL FOR PERIODONTAL EVALUATION

**Patient Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_ **Medical Alerts:** \_\_\_\_\_

Complete Periodontal Evaluation

REASON FOR REFERRAL	RADIOGRAPHS	IMPLANTS
<input type="checkbox"/> Implants <input type="checkbox"/> Soft Tissue Graft <input type="checkbox"/> Crown Lengthening <input type="checkbox"/> Guided Tissue Regeneration <input type="checkbox"/> Gingival Contouring for Cosmetics <input type="checkbox"/> Ridge Augmentation <input type="checkbox"/> Exposure Unerupted Tooth <input type="checkbox"/> Extractions; Oral/LV Sedation <input type="checkbox"/> Other	<input type="checkbox"/> Full Mouth Series <input type="checkbox"/> Periapical(s) <input type="checkbox"/> Bitewing(s) <input type="checkbox"/> Panoramic <input type="checkbox"/> Tomography <input type="checkbox"/> Being Mailed <input type="checkbox"/> Given to Patient <input type="checkbox"/> Please Take <input type="checkbox"/> No X-Rays	Preferred System: _____ Surgical Template: <input type="checkbox"/> Provided by Dentist <input type="checkbox"/> Provided by Periodontist Immediate Provisional Restoration <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Provided by Dentist <input type="checkbox"/> Provided by Periodontist

Area/Tooth of Concern: \_\_\_\_\_

Anticipated Restorative Treatment: \_\_\_\_\_

Crown & Bridge \_\_\_\_\_

Removable Prosth \_\_\_\_\_

Implants \_\_\_\_\_

Other \_\_\_\_\_

### PERIODONTAL THERAPY COMPLETED IN YOUR OFFICE (Date):

Plaque Control Instruction \_\_\_\_\_

Prophylaxis \_\_\_\_\_

Root Planing \_\_\_\_\_

Periodontal Maintenance Therapy \_\_\_\_\_

Local or Systemic Chemotherapeutic Agents \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_

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