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