PERIODONTAL REFFERAL

Millennium Periodontics
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Patient's Name: ________________________________ **Date:** ______________

Referring Dentist: ______________________ **Phone Number:** ______________

Periodontal Evaluation: ____

Scaling and root planning: ____

Oseous Surgery: ____

LANAP: ____

Crown Lengthening: Tooth # ____

Bone Graft: ____

Extract/Implant: ____

Sinus Lift: ____

Ridge Augmentation: ____

Soft Tissue Graft: ____

Frenectomy: ____

Biopsy: ____

Circle: **UR** **UL** **LB** **LL**

Teeth # ____

Have you advised patient of the possibility of extractions of any teeth? ☐ **Yes** ☐ **No**

If so which teeth? ____

PLEASE:

☐ **Call me before seeing patient** ☐ **Call me after seeing patient**

☐ **Alternate recare appointments** ☐ **Do all recare**

Your restorative treatment plans: ____

TO EXPEDITE SCHEDULING PLEASE FAX OR EMAIL THIS FORM BEFORE REMITTING TO PATIENT