Synergy Periodontics
Personalized Care • Outstanding Results

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REFERRAL FOR PERIODONTAL EVALUATION

Patient Name:_____ **Date of Birth:**_____

Telephone:_____ **Alternate. No.** _____

Email:_____ **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
❑ Esthetic Crown Lengthening		❑ Provided by periodontist
❑ Ridge Augmentation	❑ Being mailed	Immediate Provisional Restoration
❑ Exposure Unerupted Tooth	❑ Given to patient	❑Yes ❑No
❑ Extractions	❑ Please take	❑ Provided by dentist
❑ Oral/I.V sedation	❑ No x-rays	❑ Provided by periodontist
❑ Other		

Area/tooth of concern: _____

Anticipated Restorative Treatment:
Crown & Bridge _____
Removable Prosth _____
Implants _____
Other _____

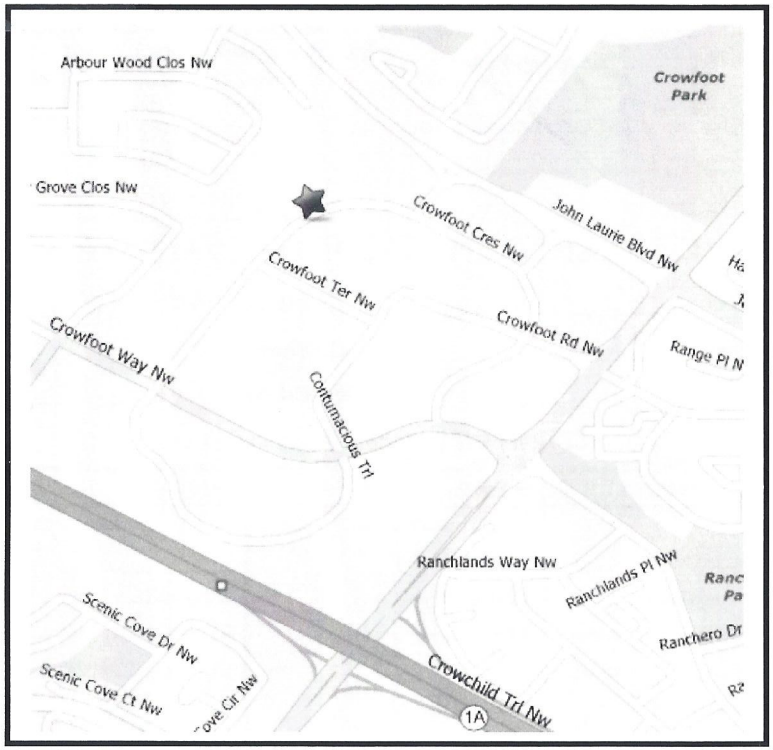
PERIODONTAL THERAPY COMPLETED IN YOUR OFFICE (date):
- ❑ Plaque Control Instruction_____
- ❑ Prophylaxis _____
- ❑ Root Planing _____
- ❑ Periodontal Maintenance Therapy
- ❑ Local or Systemic Chemotherapeutic Agents

COMMENTS:_____
_____
_____

Dr. _____ **Date:**_____

Please fax, mail or refer online through our website.
Thank you for the courtesy of your referral!

Web: www.synergyperiocalgary.com Email: info@synergyperiocalgary.com



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