ASHEVILLE PERIODONTICS
Nicole Caldwell D.D.S. P.A.

Periodontal Referral Form

Patient's Last Name: ________________________ Patient's First Name: _______________________

Referred by: Dr.______________________ Phone: ________________ Email: _________________

Reason for Referral

☐ Complete Periodontal Evaluation
☐ Gingival Contouring For Cosmetics
☐ Guided Tissue Regeneration
☐ Ridge Augmentation
☐ Crown Lengthening
☐ Graft for Root Coverage
☐ Implants
☐ Other

Radiographs

☐ Need to be taken
☐ Mailed
☐ Patient will bring
☐ Emailed

Periodontal Treatment Completed in Your Office

☐ Plaque Control Instruction
☐ Root Planing
☐ Prophylaxis and Gross Scaling
☐ Periodontal Maintenance Therapy

Have you advised the patient of the possibility of extraction of any teeth? If yes, which tooth numbers? __________________

Is there any other dentistry that needs to be completed?

Comments

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