Periodontal Referral

Precision Periodontics & Endodontics
www.precisionperiodontics.com

Patient 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** **LR** **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

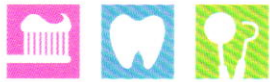
Your restorative treatments plans:_____

_____

We are located off of Exit 9, in Clifton Park.
Near the intersection of 146 and 146A, next to Key Bank
521 Vischer Ferry Road • Clifton Park, NY 12065
Phone (518) 383-4484 Fax (518) 383-4485 Email: precperio@gmail.com

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

Patient Endodontic Referral Form



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Date:_____

Patient:_____ PT. Phone:_____

Referred by Dr.:_____ Dr. Phone:_____

Address:_____

Right	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Left
	32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17

Reason for Referral:

❑ Localized pain / swelling or ❑ non-localized pain
❑ Clinical / radiographic pulp exposure
❑ Radiographic pathology
❑ Retreatment
❑ Apicoectomy
❑ Crack / fracture suspected
❑ Elective root canal therapy
❑ Other:_____

Services Needed:

❑ Eval. & Treat.
❑ Eval. only
❑ Consultation
❑ Prepare post space
❑ Other:_____
_____

Services Needed:

❑ Simple restorative / seal access opening
❑ Crown & bridge
❑ Post space required
❑ Treatment by periodontist
❑ Other:_____

Comments:_____
_____
_____
_____

Referring Doctor's Signature :_____

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