ADVANCED PERIODONTICS OF WASHINGTON

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Date: ____________________

Patient Name ____

Telephone Home : ____________________ Work : ________________________

Referring Dentist: _________________________ ❒ Send additional referral pads

PERIODONTAL / IMPLANT REFERRAL

❒ Requires Complete Periodontal Examination

❒ Evaluate isolated area ______________________________________

❒ Extraction ______________________________________

❒ Implants ______________________________________

❒ Crown Lengthening ______________________________________

❒ Soft Tissue Graft ______________________________________

❒ Oral Pathology / Biopsy ______________________________________

❒ Pre-Orthodontic evaluation ❒ CBCT___________________

RADIOGRAPHS: ❒ Please take ❒ Given to patient ❒ Mailed

COMMENTS: ____

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<u>FOR NEW PATIENTS</u>: Please be prepared to provide a complete list of your current medications. If you require antibiotic pre-medication for dental appointments, please pre-medicate for your initial visit. If you have been prescribed a blood thinning medication, please inform the office when making your appointment.