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______________________ , 20 ____
DATE OF REFERRAL

This is to introduce____.

I. Please evaluate/consult

____for generalized periodontal disease
____for generalized periodontal restorative needs
____for specific area(s)______________________________________
____

____of immediate concern/high priority________________________
____

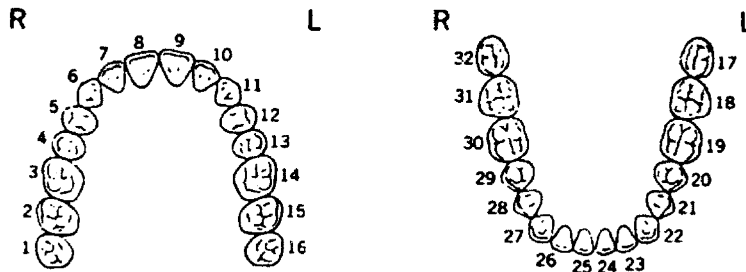
II. The patient has been in my practice since_____________________
Frequency of recall__________________Most recent cleaning__________
Existing restorations were done (approx)___________________________
____in this office ____by a previous dentist
Restorative treatment____is completed; ____is established;
____is pending outcome of periodontal findings.

Special health concerns are_______________________________________.
Other referrals: Endo____ Oral Surgery____ Ortho____ MD____

III. My treatment to date has included

	Therapy Performed	Plan to Do
Initial Exam/Consult		
Emergency Care		
Preventative Care		
Oral Hyg Instr		
Initial Root Pl/Sc		
Periodontal		
Restorative		
Root Canal tx.		
Extraction		
Significant Problems		

IV. My tentative treatment plan is



V. X-RAYS (date)
____FMX ____Bite Wings ____P.A. ____Panorex
____Not Available ____Please take and send copy
____Enclosed ____Please Return ____Keep

VI. Additional Comments (i.e. attitude, commitment, finances, your suggestions)

____
____
____
____

Please call me concerning your evaluation.

REFERRED BY: DR.______________________________ PHONE________________