Periodontal Center of Excellence

Kip W. Saunders, D.D.S., M.S.

Patient: _____ Date: _____

I am Referring This Patient For:

- ❑ Periodontal Evaluation & Treatment _____
- ❑ Implant Consultation _____
- ❑ Crown Lengthening _____
- ❑ Recession _____
- ❑ Frenum Problem _____
- ❑ Other: _____

Periodontal Treatment Done by Referring Office:

- ❑ Root Planing and Scaling – UR / UL / LR / LL Date Done: _____
- ❑ Frequent Periodontal Maintenance: _____

Radiographs: (FMX _____ Pano _____ PA's ____ CBCT____)

Please forward referral and x-rays to ***frontdesk@periocenter.com*** prior to patient's visit.

Treatment Discussion:

Please call me: ❑ Not necessary ❑ Before ❑ After ❑ your examination

Restorative Thoughts: _____

_____

_____

Doctor: _____

Phone: _____ Fax: _____

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