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## PERIODONTAL REFERRAL LETTER

DATE: \_\_\_\_\_

REFERRAL FROM DR. \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

PATIENT PHONE NUMBER: \_\_\_\_\_

### Please evaluate the patient for the following:

PERIODONTAL DISEASE: \_\_\_\_\_

RECESSION / GRAFTING: \_\_\_\_\_

IMPLANT: \_\_\_\_\_

CROWN LENGTHENING: \_\_\_\_\_

OTHER: \_\_\_\_\_

AREAS OF CONCERN OR SPECIAL INSTRUCTIONS: \_\_\_\_\_

### Additional Information:

PREVIOUS PERIODONTAL TREATMENT(S): \_\_\_\_\_

PATIENT IS IN PAIN

### Radiographs:

*\*Please email x-rays to [office@goldsboroperio.com](mailto:office@goldsboroperio.com)\**

TYPE: \_\_\_\_\_

DATE: \_\_\_\_\_

PLEASE TAKE AN FMX AND SEND IT TO ME

### Patient Appointment:

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_