West Tennessee
PERIODONTICS &
DENTAL IMPLANTS

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PERIODONTAL, LASER &
DENTAL IMPLANT THERAPY

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REFERRED BY _____ DATE _____

PATIENT'S NAME _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

**An appointment has been reserved for you on:** DAY _____ DATE _____ TIME _____

**Anticipated restorative plans include:** _____

_____

_____

☐ **Premedication required**

☐ **Patient is new to your practice**

**This patient is being referred for evaluation and treatment:**

- ☐ COMPREHENSIVE PERIODONTAL EXAMINATION
- ☐ AREA OF SPECIAL CONCERN #(S)_____
- ☐ SOFT TISSUE GRAFTING/ GINGIVAL RECESSION #(S)_____
- ☐ EVALUATION FOR IMPLANTS #(S)_____
- ☐ PERIODONTAL-PROSTHETIC TREATMENT PLANNING #(S)_____
- ☐ CROWN LENGTHENING ON #(S)_____
- ☐ EVALUATION OF ORAL LESIONS/PATHOLOGY #(S)_____
- ☐ OTHER _____

**Appointment status:**

- ☐ MADE BY OUR OFFICE
- ☐ YOUR OFFICE TO CALL PATIENT
- ☐ PATIENT WILL CALL

**Communication:**

- ☐ CALL ME REGARDING THIS PATIENT
- ☐ BEFORE APPOINTMENT
- ☐ AFTER APPOINTMENT
- ☐ NO NEED TO CALL–WRITTEN CORRESPONDENCE WILL SUFFICE

**Recent full-mouth x-rays:**

- ☐ ACCOMPANY PATIENT
- ☐ MAILED
- ☐ E-MAILED
- ☐ NOT AVAILABLE

**WHITE** PATIENT'S COPY

**YELLOW** REFERRING DOCTOR'S COPY