FORT WAYNE
**Periodontal & Implant Specialists**

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# Periodontal Referral Form

## Patient Information

First Name: _____ Date of Birth: _____

Last Name: _____

Phone: _____ E-mail: _____

☐ Patient will call for appointment ☐ Please call patient

## Referred for the Following

☐ Complete Periodontal Evaluation
☐ Implants
  ☐ Biohorizon ☐ Straumann
  ☐ Other _____
☐ Graft for Root Coverage
☐ Crown Lengthening
  Teeth # _____
☐ CBCT
☐ Guided Tissue Regeneration
  Teeth # _____
☐ Gingival Contouring for Cosmetics
  Teeth # _____
☐ Ridge Augmentation
☐ Frenectomy
☐ Osseous/Laser Periodontal Surgery
☐ Exposure of impacted teeth

**Remarks:** _____

## Possible Extractions

Have you advised the patient of the possibility of extraction? If so, which tooth number (s):

## Radiographs or Clinical Photos:

*(with dates)*

☐ Being Mailed
☐ Being Emailed
☐ Given to Patient
☐ No X-ray, please take
☐ FMX
☐ BWX
☐ Pano
☐ PA

## Periodontal treatment completed in your office:

☐ Plaque Control Instructions
☐ Root Planing (Dates: _____ _____ _____)
☐ Prophylaxis and Gross Scaling
☐ Periodontal Maintenance Therapy

## Referring Doctor

Name: _____ Phone: _____

**Fort Wayne**
7750 W. Jefferson Blvd.
Fort Wayne, IN 46804

**Warsaw**
2283 Provident Court
Warsaw, IN 46580

**Van Wert**
1167 Westwood Drive
Van Wert, OH 45891

**Board Certified Periodontist*