

From Dr. _____ Date _____

- PATIENT INFORMATION -

Introducing My Patient: _____

Street Address: _____ Home Phone: _____

Enclosed Are: Radiographs.... Check if E-Mailed Cell Phone: _____

Periodontal Charting Work Phone: _____

- TREATMENT REQUIREMENTS -

Please provide emergency treatment to the following areas: _____

Please provide complete evaluation and treatment:

Areas I am specifically concerned about:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Please call me at _____, because I need to explain the restorative needs in more detail.

Please evaluate the need for gingival grafting procedure in the area of _____ to:

Add attached keratinized tissue Augment defective ridge

Cover exposed root surface(s)

Please evaluate and discuss the need for endosseous root form implants in the following areas:

Other: _____

- RADIOGRAPHS (Not Required for Referral) -

Keep the enclosed radiographs for your records Take radiographs as needed and:
 E-mail copy Mail copy

- TREATMENT RENDERED to THIS PATIENT -

Periodontal Stage

Prophy: UR UL LR LL ALL

Scaling & Root: UR UL LR LL ALL

Surgery: UR UL LR LL ALL

Maintenance

Restorative Stage

TX Planned: UR UL LR LL ALL

Intermediate/
Temporized: UR UL LR LL ALL

Completed: UR UL LR LL ALL

- APPOINTMENT -

The appointment has been scheduled for: _____ at _____:

Jeff Fleming, D.D.S., M.S. Garry Millard, D.D.S.