LEGACY
PERIODONTICS & IMPLANT CENTER

Periodontal Referral Form

Guest Name: _____ DOB: _____ Weight: _____

Referring Dentist: _____ Office: _____

Right **Circle Tooth Number Below:** **Left**

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

Date of Exam:_____

Reason for Perio Referral:

- ☐ Evaluation only: _____
- ☐ Implant
- ☐ Tissue Graft
- ☐ Implant Tissue Graft
- ☐ Tooth Exposure (Ortho)
- ☐ Other:
- ☐ Bone Graft /Regeneration / GBR
- ☐ Osseous Surgery
- ☐ Gingivectomy
- ☐ Frenectomy
- ☐ Crown Lengthening

Has the guest had previous periodontal therapy? Yes / NO If yes, provide the date: _____

Please answer the following questions:

Is a Medical Clearance needed prior to scheduling? ☐ Yes ☐ No

Are x-rays updated and clinically acceptable? ☐ Yes ☐ No

Does the Guest need any special care? ☐ Yes ☐ No
- Guest with dental anxiety, special needs, behavior issues, talkers, etc

Is a removable partial device needed day of EXT? ☐ Yes ☐ No ☐ N\A
- Immediate denture, flipper, etc.

Is there a restorative plan if implants are being placed? ☐ Yes ☐ No ☐ N\A
- If Yes: _____

Additional Comments:_____

Doctor Signature:_____ **Date:**_____

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