Contemporary Periodontics
& Implant Dentistry

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Diplomate, American Board of Periodontology

FAX REFERRAL
FAX TO 578-8500
NO COVER SHEET REQUIRED

Date:_____

Introducing: _____

Home Phone _____Work Phone_____Cell Phone _____

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

Please evaluate for:

❑ Dental Implants ❑ Pocketing/Bone Loss ❑ Diagnosis/TX Plan
❑ Crown Lengthening ❑ Mucogingival Defect ❑ 3D Scan ❑ Other _____

Remarks/Instructions: _____

_____

❑ FMX dated_____ ❑ Panoramic dated_____

❑ PA of_____ dated _____ ❑ Take new ❑ FMX ❑ PA #_____ ❑ Panoramic

❑ Will be mailed _____ ❑ Sent with patient

❑ Emailed to xrays@contemporaryperio.com

Referred by Dr.:_____

My Treatment Plan includes:_____

_____

_____

_____

Appointment: Date: _____Time: _____ ❑ a.m. ❑ p.m.