PerioHealth

Vani Prabakaran, DDS, MS
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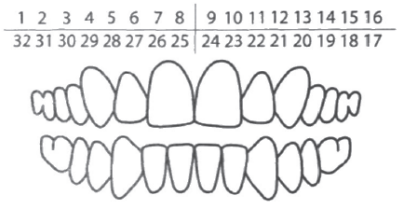
E:office@periohealthswfl.com

Date: _____
Introducing: _____Ph. number: _____
Referring Doctor: _____
Appointment Date and Time: _____
48 hours notice is necessary if unable to honor appointment

PLEASE BRING THIS FORM TO YOUR APPOINTMENT

Referral for:



- ☐ Complete periodontal evaluation
- ☐ Limited periodontal evaluation, area(s): _____
- ☐ Evaluation for LANAP/LAPIP
- ☐ Esthetic gingival recontouring
  - ☐ Gingival asymmetry
  - ☐ Gummy smile
  - ☐ Ridge augmentation for esthetics in pontic area
- ☐ Gingival recession/mucogingival defect, area(s): _____
  - ☐ Evaluation for Chao Pinhole Technique
  - ☐ Frenectomy in conjunction with tissue grafting
- ☐ Dental implant evaluation, area(s): _____
  - ☐ Extraction and Ridge Preservation
  - ☐ GBR/Bone Grafting
  - ☐ Sinus Lift
- ☐ Orthodontic Co-Therapy
  - ☐ Tooth Exposure, area(s): _____
  - ☐ TAD Placement, area(s): _____
  - ☐ Piezocision, area(s): _____
- ☐ Other: _____

Restorative Treatment Plan: _____

_____

FMX and BW: ☐ To be emailed ☐ To be mailed ☐ Please take and send

Patient has received:

- ☐ Perio Maintenance/OHI (mo. /yr.)
- ☐ Root Planing (mo. /yr.)
- ☐ Previous perio therapy (mo. /yr.)
- ☐ New Patient
- ☐ Patient of Record since (mo. /yr.)

Please:

- ☐ Call me before evaluation of this patient
- ☐ Call me after evaluation of this patient
- ☐ Send Correspondence

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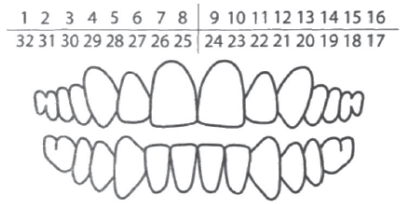

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