

PERIODONTAL REFERRAL

Referring Doctor Information:

Dr. _____ Date Referred _____

Phone _____ Email _____

Patient Information:

Name _____

DOB _____ Home Phone _____

Email _____ Cell _____

X-rays FMS Partial x-rays (# of films _____) PAN CBCT

emailed to drjyuperio@gmail.com date taken _____ None

Recall routine _____ months irregular last appt date _____

Reason for Referral:

Comprehensive periodontal exam & treatment

Specific exam

Recession Crown lengthening Pocket Reduction / Bone grafting

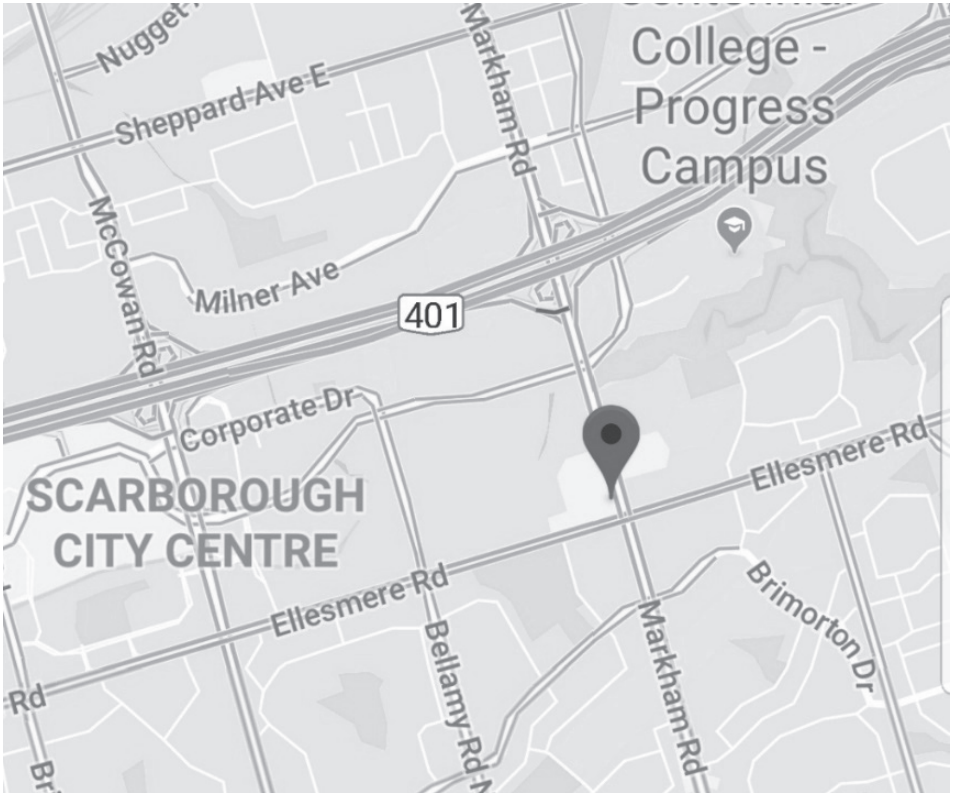
Frenectomy Unerupted tooth exposure Other _____

Implant consult

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Comments (pre-med, restorative treatment plan)

Appointment Date & Time _____



2100 ELLESMERE ROAD – SUITE 308

LOCATED ON THE NW CORNER OF MARKHAM RD. & ELLESMERE RD.

FREE PARKING AVAILABLE

SURFACE LOT AND ABOVE GROUND COVERED PARKING GARAGE