

# Satya R. Molleti, BDS, MS

Diplomate, American Board of Periodontology

Phone: 952.926.3128 Fax: 651.212.2577

www.thedentalspecialists.com

40 Nicollet Blvd W, Burnsville, MN 55337

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Phone \_\_\_\_\_

I am referring my patient to you for a periodontal evaluation of the following (marked) areas:

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

Remarks: \_\_\_\_\_

Restorative/prosthetic treatment contemplated: \_\_\_\_\_

Full mouth x-rays will be sent:  To the practice  With patient

Appointment Date \_\_\_\_\_ Time \_\_\_\_\_

Referring Doctor \_\_\_\_\_

Referring Practice \_\_\_\_\_

Email \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

