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Diplomate, American Board of Periodontology

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❑ 6437 Brooklyn Blvd, Suite 200, Brooklyn Center, MN 55429

❑ 15701 Grove Circle North, Maple Grove, MN 55369

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
RIGHT																**LEFT**
	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 _____

TDS THE DENTAL SPECIALISTS

PERIODONTICS