

Date: _____

Patient Name: _____ Patient Phone Number: _____

Referring Dentist: _____ Dentist Phone Number: _____

- Comprehensive periodontal examination _____
- Localized periodontal examination (#: _____)
- Periodontal (osseous) surgery (#: _____)
- Gum recession (#: _____)
- Gingivectomy/plasty(#: _____)
- Crown lengthening (#: _____)
- Extractions/site preservation (#: _____)
- Implant (s) (#: _____)
- Management of implant complications/peri-implantitis (#: _____)
- Soft tissue biopsy (#: _____)
- Other; please specify _____

History of scaling/root planing (quadrant /date) _____

***Please email any current radiographs including recent full mouth series or panoramic films within the past 5 years to dentalimages@ccf.org**