ARIZONA Periodontal GROUP

ARIEL E. TRUJILLO, DMD • DIPLOMATE, AMERICAN BOARD OF PERIODONTOLOGY

**Patient's Name:** _____ **Date:** _____

**Referred by Dr.:** _____ **Phone:** _____

# PERIODONTAL REFERRAL FORM

*Reason for Periodontal Referral:*

❑ Complete Periodontal Evaluation: _____

❑ Periodontal Evaluation of a Localized Area: _____

❑ Dental Implant Consultation: _____

❑ Other (Please Specify): _____

❑ Periodontal Preventative Maintenance:

Yes _____ No _____ Date: _____

❑ SRP Performed: Yes_____ No_____

Date: _____/_____/_____/_____
URQ LRQ ULQ LLQ

❑ Current Films Available: Yes_____ No_____

FMX_____ (Date_____) BWs_____ (Date_____) PAs_____ (Date_____) PANO_____ (Date_____)

❑ None. Please take necessary films and send us duplicates.

Notes: _____

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