Periodontal Associates

Specialists in Periodontology & Dental Implants

1171 Murrieta Blvd., Suite 200, Livermore, CA 94550
Phone: (925)449-6633 Fax: (925)449-0766
Website: www.perioassoc.com Email: perioassoc@hotmail.com

Introducing: _____ Date: _____

Patient Phone #: _____

Referring Doctor: _____ Referring Doctor Phone #: _____

REASON FOR REFERRAL: (select all that apply)

m Comprehensive Full Mouth Periodontal Exam (Please send FM ith referral)
m Periodontal Sur ery (osseous poc et reduction) area(s):
m Laser Assisted e Attachment Procedure (LA AP) or LAP P, area(s):
m Dental mplant Extraction ith Soc et Preservation, area(s):
m Rid e Development (BR, sinus lift):
m Recession, Soft Tissue raftin (root covera e, Pinhole sur ery), area(s):
m Cro n Len thenin , area(s):
m All-on-4 evaluation, indicate arch: _____
m Frenectomy, area(s): _____
m Gingival Recontouring (gingivectomy) area(s): _____
m Other: _____

PERIODONTAL TREATMENT COMPLETED IN YOUR OFFICE:

- o Scaling and root planing, completed on: _____
- o No history of scaling and root planing:
  If scaling and root planing is needed, is patient to return to your office for treatment? YES NO
- o Last periodontal maintenance/prophylaxis: _____

RADIOGRAPHS:

- o emailed to perioassoc@hotmail.com
- o patient will bring CT
  ***FMX required for full perio eval**

REFERRED TO:

- o Shayna Rondon, DDS MS
- o Elena Sanz-Miralles, DDS MS MSc PhD
- o No Preference

ADDITIONAL COMMENTS:

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3 Ways To Return This Form:

1. **Email our office at**: perioassoc@hotmail.com
2. **Fax to**: (925) 449-0766
3. **Mail to**: Periodontal Associates 1171 Murrieta Blvd., Suite 200 Livermore, CA 94550