Taschner Periodontics
PERIODONTAL THERAPY & DENTAL IMPLANTS

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Diplomate of the American Board of Periodontology

PATIENT'S NAME_____ **REFERRING DR.** _____

APPOINTMENT DATE & TIME:_____ **TODAY'S DATE:**_____

REASON FOR REFERRAL AND CONCERN:

( ) Complete periodontal evaluation: _____

( ) Implant evaluation; tooth no(s). or area(s): _____

( ) Recession/inadequate attached gingiva/soft tissue grafting; tooth no(s).____

( ) Functional crown lengthening, tooth no(s).____

( ) Esthetic crown lengthening/gingival contouring; tooth no(s). _____

( ) Ridge augmentation to enhance esthetics in pontic area; area(s) _____

( ) Other _____

TENTATIVE RESTORATIVE TREATMENT PLAN:

( ) Restorative consultation desired after periodontal consultation
( ) Restorative already completed
( ) Minor restorations only

PRIMARY RESTORATIVE TREATMENT PLAN:

SECONDARY RESTORATIVE TREATMENT PLAN:

DOCTOR'S CONCERNS:

PATIENT'S CONCERNS/FEARS/MOTIVATORS:

X-RAYS:

( ) Full mouth series taken within last year enclosed
( ) Take necessary x-rays and send duplicate set for my records
( ) Bitewings enclosed
( ) Pano enclosed
( ) Please return x-rays
( ) You may keep the x-rays for your records
( ) X-rays being sent via email

CORRESPONDENCE:

( ) Send correspondence via email to referring dentist

Please retain the Yellow copy for your records.

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