SELECT PERIO

Diplomats of the American Board of Periodontology

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PATIENT NAME: ______________________________ DATE: ____________________

REFERRING DR: ____

REASON FOR REFERRAL: *(Please fax/email this form upon patient referral)*

❒ *Complete Periodontal Evaluation:* ______________________________

❒ *Crown Lengthening:* **M D F L P 360°** *Tooth no. (s)* ______________________

❒ *Soft Tissue Consideration: Tooth no.(s)* ______________________

- ❒ *Gingival Recession* ______________________
- ❒ *Inadequate Attached Gingiva* ______________________

❒ *Ridge Augmentation: Tooth no.(s)* ______________________

- ❒ *Pontic Site* ______________________
- ❒ *Edentulous for Future Implant Site:* ______________________
- ❒ *Socket Preservation at Time of Extraction:* ______________________
- ❒ *Maxillary Sinus Proximity:* ______________________

Implant System Preferred: ❒ *3i* ❒ *Nobel Biocare* ❒ *Straumann* ❒ *Astra* ❒ *Zimmer* ❒ *Other*

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

PERIO PROSTHETIC EVALUATION:

❒ *Maxillary* ❒ *Mandbibular*

Perio Ortho Consideration: ______________________

❒ *Exposure of Impacted Teeth* ______________________

❒ *PAOO (Corticotomy) / SFOT* ______________________

❒ *Frenectomy* ______________________

Laser LANAP Periodontal Therapy / Laser Assisted Therapy

COMMENTS: ____

X-RAYS: ❒ *given to patient* ❒ *will be sent by mail* ❒ *will be emailed* ❒ *FMX* ❒ *PANO* ❒ *CT*
❒ CBCT Cone Beam Computed Tomography

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Forms can be downloaded from our website | Email referrals to: xrays@selectperio.com
www.selectperio.com
We are open Monday thru Friday 8:00am - 6:00pm | Saturday 9:00 - 5:00