

# Professional Periodontics and Dental Implants

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## *Referral for Consultation*

Introducing \_\_\_\_\_

Patient's Telephone number \_\_\_\_\_

Referred by Dr. \_\_\_\_\_

Date of Referral \_\_\_\_\_

General Periodontal Evaluation

Dental Implant Evaluation

Specific Periodontal Evaluation  
(Please indicate area of concern)

Gingival Recession

Crown Lengthening

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

Radiographs:  Emailed  Sent  Please take as needed

Comments \_\_\_\_\_

\_\_\_\_\_

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