ENCINO DENTISTRY
PERIODONTICS & IMPLANT DENTISTRY

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Patient Referral Form

Referring Dentist:

Doctor's Name: _____ Today's Date: _____

Office Phone: _____ Email: _____

Patient Details:

Appt Date: _____

Patient Name: _____ Time: _____

Date of Birth: _____ Phone Number: _____

Specific Areas of Concern:

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

Reason for Referral

- ☐ Comprehensive Periodontal Care
- ☐ Periodontal Regeneration
- ☐ Treatment of Gingival Recession
- ☐ Esthetic Tissue Contouring
- ☐ Treatment of Excessive Gingival Display (Gummy Smile)
- ☐ Crown Lengthening
- ☐ Implant: site _____
- ☐ Peri-Implant Disease Therapy
- ☐ Alveolar Ridge Augmentation
- ☐ Sinus Augmentation
- ☐ Extraction
- ☐ Ridge Preservation Socket Grafting
- ☐ All-On-4 Implant Therapy
- ☐ Vestibuloplasty
- ☐ Surgically Facilitated Orthodontic Therapy (SFOT)
- ☐ Mucosal Pathology
- ☐ Osseous Pathology
- ☐ Other _____

History of Periodontal and Implant Therapy

	Site	Date
Prophylaxis		
Scaling and root planning		
Periodontal Surgery		
Tooth Extraction		
Bone Graft		
Dental Implant		

Direction To Encino Dentistry

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Comments:

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