Ocala Periodontics & Dental Implants

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Please visit our website at www.ocalaperio.com

Patient Information

Date of Referral _____/_____/_____

Name: Mr. / Ms. / Mrs. / Dr. _____ D.O.B. _____/_____/_____

Telephone: cell / home / work (_____) _____ Email: _____

☐ Patient is scheduled in your office on_____/_____/_____at _____:_____ am / pm

☐ Patient will contact your office ☐ Please contact patient to schedule

Referring Doctor

Dr. _____ Email: _____

Office Phone:_____ Office Fax: _____

☐ Please call me to discuss this case before / after your examination

Reason For Referral

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

☐ Periodontal Disease
☐ Gingival Recession
☐ Crown Lengthening
☐ Dental Implants
☐ Dental Implant Site Development
☐ Extractions
☐ IV Sedation
☐ Alveoloplasty
☐ Tori/Exostoses Removal
☐ Oral Pathology/Biopsy
☐ Impacted Tooth Exposure
☐ Frenectomy
☐ Hemangioma Removal
☐ CT Scan - Please Complete CT Prescription Form
☐ Other _____

☐ LANAP/LAPIP
☐ Pinhole Surgical Technique

Restorative Plans

1. _____
2. _____
3. _____
4. _____

Radiographs Available:	**Date Taken**
☐ FMX	____/____/____
☐ BWX	____/____/____
☐ PANO	____/____/____
☐ PAs	____/____/____

Sending by:
☐ Email
☐ Mail

Periodontal Treatment Completed in Your Office

	Dates Completed
☐ Debridement	____/____/____
☐ Scaling & Root Planing	____/____/____
☐ Periodontal Maintenance	____/____/____

Notes _____