Baldwin

PERIODONTICS & IMPLANT DENTISTRY

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baldwinperio.com

Date:

Referring office/doctor:

Patient’s name/DOB:

Patient’s phone:

Reason for referral

* Comprehensive periodontal exam
* Limited exam of
* Scaling and root planing/Re-evaluation
* Crown lengthening
* Recession/mucogingival defect
* Bone grafting
* Implant
* Biopsy
* Other:

Site

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

* Take as needed
* Emailed
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Periodontal treatment completed in your office

* SRP (Date: )
* Prophylaxis/Recall every \_\_months (most recent: )
* Other:

Tentative Restorative Plan:

Remarks:

* Please contact me at after seeing this patient.