BEAVERTON PERIODONTICS

14780 SW Osprey Drive, Suite 240A
Beaverton, OR 97007
Office: 503-747-0095 | Fax 503-747-0027
info@beavertonperiodontics.com
www.beavertonperiodontics.com

RIVERPLACE PERIODONTICS

2636 SE Harrison St. Ste A
Milwaukie OR 97222
Office 503-654-5405 | Fax 503-654-5406
info@riverplaceperio.com
www.riverplaceperiodontics.com

Referring Doctor: _____ Phone: _____ Date:_____

Introducing Patient: _____ Phone: _____

Pertinent Medical History: _____ (ie: Antibiotic Pre-Med): _____

APPOINTMENT: ☐ Made For Patient: Date: _____ Time: _____

☐ Patient instructed to call for an appointment: _____

☐ Please contact patient for appointment: Contact phone: _____

NATURE OF REFERRAL:

- ☐ Dental Implants
- ☐ Soft Tissue Grafts
- ☐ Recession/Mucogingival Defects
- ☐ Laser Periodontal Therapy
- ☐ Periodontal Disease
- ☐ Isolated Area (Teeth #s _____)
- ☐ Crown Lengthening Biopsy
- ☐ Biopsy
- ☐ CT Scan
- ☐ Other _____

AREA OF CHIEF CONCERN:

			A	B	C	D	E	F	G	H	I	J			
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
			T	S	R	Q	P	O	N	M	L	K			

RADIOGRAPHS:

- ☐ Were: mailed (date) _____ emailed (date)_____
- ☐ Sent with patient
- ☐ Please take

For the most thorough diagnosis and treatment a recent FMX is requested

Reason for referral and/or comments: _____

_____

_____

_____

Tentative Restorative Treatment Plan: _____

_____

_____