



Periodontal Care, P.A.
Healthy Gums, Healthy Heart

Adam C. McClellan, DDS
and Associates

REFERRAL

DATE _____

PATIENT _____

PATIENT PHONE _____ PATIENT AGE _____

REFERRING DOCTOR _____

1. FAX this form (See back for #) • 2. Give Patient the Original

In order for us to have a timely appointment and develop a complete treatment plan for your patient, please fill out entirely.

- HISTORY**
- New to our practice
 - Been in our practice for ____ years
 - Previously completed periodontal treatment _____
 - Planned dental treatment _____
 - Next appointment scheduled in our office _____ for _____

- REQUEST**
- Comprehensive periodontal evaluation
 - Limited periodontal evaluation of _____
 - Dental Implant(s) or Pre-Implant tooth extraction or augmentation
 - Soft tissue graft Crown lengthening
 - Frenectomy (Facial Only) Esthetic recontouring of the anterior gingiva
 - 3D scan of _____ (South office only)
 - Other _____

LOCATION

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	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

COMMENTS

Unless other arrangements have been made, your patient's first appointment in our office will always be for an examination/consultation prior to having the procedure performed on a separate day.



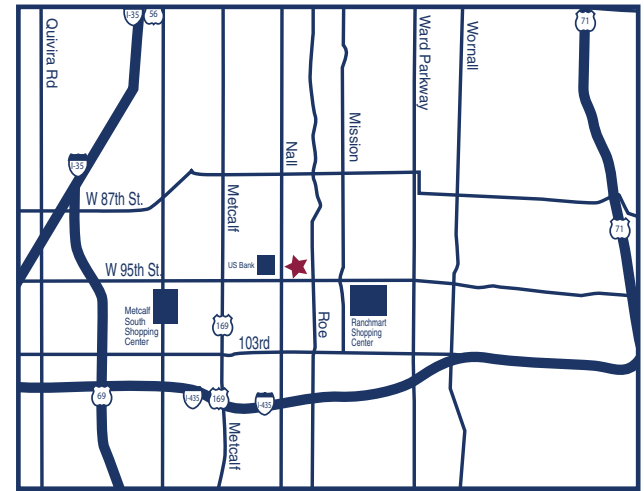
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www.PeriodontalCarePA.com

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