Ivelina Dean, DMD, MDS, MBA

Periodontist

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PERIODONTAL REFERRAL FORM

Date: ____________________

Patient Name: ______________________________ Patient Phone Number: ____________________

Referring Dentist: ______________________________ Office Phone Number: ____________________

❑ Consultation Only ❑ Consultation and Treatment

Service Requested:

- ❑ Full Mouth Periodontal Evaluation & Tx
- ❑ Isolated Periodontal Evaluation & Tx
- ❑ Muco-Ginigival Surgery
- ❑ Bone Grafting
- ❑ Gingivectomy
- ❑ Cuspid Exposure
- ❑ Implant Consultation
- ❑ Preprosthetic surgery/crown lengthening
- ❑ Cone Beam CT Scan

How do you want this returned? ____________________

UPPER RIGHT								UPPER LEFT							
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
LOWER RIGHT								LOWER LEFT							

❑ **Full Mouth** ❑ **Upper Right (UR** ❑ **Upper Left (UL)**

❑ **Lower Right (LR)** ❑ **Lower Left (LL)**

Radiographs:

❑ Please Take ❑ Emailed to: info@ayrsleyfamilydentistry.com - Attn: Dr. Dean

Periodontal Treatment Previouslv Done:

❑ Scaling & Root Planing: UR LR UL LL Date Completed ____________________

❑ Frequent Periodontal Maintanence

Comments: ____

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MAP OF OUR LOCATION ON BACK

2135 Ayrsley Town Boulevard, Suite F • Charlotte NC 28273