REFERRING DOCTOR: _____ ***DATE:*** _____

THIS IS TO INTRODUCE: *PATIENT:* _____

TELEPHONE: _____

TREATMENT 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

COMMENTS: _____

_____

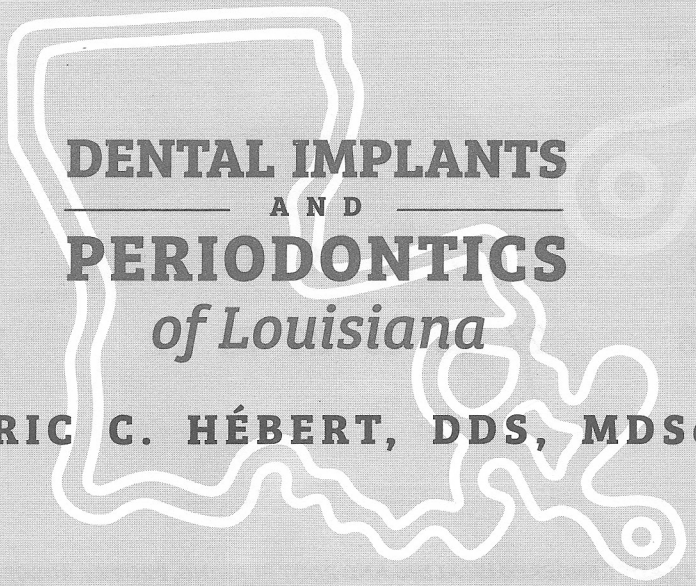
PERIODONTAL TREATMENT ALREADY RENDERED (SCALING AND ROOT PLANING, PROPHY, SURGERY):

_____

X-RAYS AVAILABLE (FMX, BITEWINGS, PA) & DATE TAKEN:

_____

☐ ***PATIENT WILL BRING X-RAYS*** ☐ ***EMAILING X-RAYS*** ☐ ***MAILING X-RAYS***



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