MDP MINOT DENTAL PARTNERS
Center for Endodontics, Periodontics and Implant Dentistry

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Periodontics and Implant Dentistry

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Periodontal Referral Notice

Date: ____________________________

Patient Name: ____________________________

Phone Number: ____________________

Evaluation of Tooth/Teeth _____________:

- ☐ Implants
- ☐ Crown Lengthening
- ☐ Recession (root coverage)
- ☐ Ridge Augmentation
- ☐ Regeneration
- ☐ Sinus lift
- ☐ Periodontal disease
- ☐ Extraction with implant placement
- ☐ Mucogingival defect
- ☐ Furcation involvement
- ☐ Prior to restoration
- ☐ Other

Specific Restorative Plans:

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Radiographs:

- ☐ Radiographs with patient
- ☐ Radiographs to be mailed before appointment
- ☐ Radiographs to be emailed before appointment
- ☐ Please take any necessary radiographs

Referring Doctor:

Name: ____

Phone: ____

Address: ____