SaultArea PERIODONTICS

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Patient Name: ______________________________ Phone #: _______________

Referred by Dr. _______________________ Date of referral: _________________

Reason for referral:

☐ Complete Periodontal Evaluation

☐ Specific Periodontal Evaluation (please specify tooth/area) ______________

☐ Soft tissue grafting ☐ Osseous / regenerative surgery

☐ Crown Lengthening ☐ Ortho-related (frenectomy, exposure, etc.)

☐ Other: _________________________

☐ Implant consultation (please list possible sites) ________________________

☐ Biopsy (please provide history and description of lesion) ________________

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Recent radiographs:

☐ unavailable, please take new radiographs ☐ with patient

☐ mailed to your office ☐ emailed to *info@saultperio.com*

Most recent hygiene visit: ______________________________

Comments: ____

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Please fax to 705.450.1012 or email to info@saultperio.com

Additional forms can be downloaded at www.saultperio.com