



Referring Dentist: _____ Off Ph _____ Date: _____

Patients Name: _____ Hm Ph _____ WkPh _____

Patients Address _____ Zip Code: _____

- Patient will call us. You wish us to call the patient

Type of Exam:

- Complete Perlo Exam
 Isolated Area. Explain: _____

 Implant Exam

Radiographs:

- Date of most recent FMX series: _____
(Note: Past years X-rays appreciated)
 X-rays emailed to info@s.periopdx.com
 Please schedule FMX in Perlo office

**The Following
Has Been
Completed:**

- Emergency Operatives.
 Gross Scale & Polish. Date: _____
 Root Planing and Curettage.
No. of Appts: _____ Date: _____
 Extensive Oral Hygiene Instructions.
 No Perio Treatment Rendered.

**Patient
Information:**

- New Patient Regular Care Irregular Care PreMed
 Other Family Member Referred. Name: _____
 High Dental Anxiety

**Restorative
Treatment Plan:**

- In Progress: _____

 Future Plans: _____

 Alternatives: _____

Comments

