



14780 SW OSPREY DRIVE, SUITE 240A
 BEAVERTON, OR 97007
 OFFICE: 503-747-0095 | FAX 503-747-0027
 INFO@BEAVERTONPERIODONTICS.COM
 WWW.BEAVERTONPERIODONTICS.COM

1130 SE 122ND AVENUE
 PORTLAND OR 97233
 OFFICE 503-252-5515 | FAX 503-255-1625
 INFO@PERIOPDX.COM
 WWW.PERIOPDX.COM

2636 SE HARRISON ST. STE A
 MILWAUKIE OR 97222
 OFFICE 503-654-5405 | FAX 503-654-5406
 INFO@RIVERPLACEPERIO.COM
 WWW.RIVERPLACEPERIODONTICS.COM

Referring Doctor: _____ Phone: _____ Date: _____

Introducing Patient: _____ Phone: _____

Pertinent Medical History: _____ (ie: Antibiotic Pre-Med): _____

APPOINTMENT: Made For Patient: Date: _____ Time: _____

Patient instructed to call for an appointment: _____

Please contact patient for appointment: Contact phone: _____

NATURE OF REFERRAL:

- Full Arch Implants
- Dental Implants
- Soft Tissue Grafts
- Recession/Mucogingival Defects
- Laser Periodontal Therapy
- Periodontal Disease
- Isolated Area (Teeth #s _____)
- Crown Lengthening
- Biopsy
- Other _____

AREA OF CHIEF CONCERN:

			A	B	C	D	E		F	G	H	I	J			
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
			T	S	R	Q	P		O	N	M	L	K			

RADIOGRAPHS:

- Were: mailed (date) _____ emailed (date) _____
- Sent with patient
- Please take

*For the most thorough diagnosis and treatment
 a recent FMX is requested*

Reason for referral and/or comments: _____

Tentative Restorative Treatment Plan: _____

