



**Reynoldsburg Periodontics
& Dental Implants**

PATIENT REFERRAL SLIP

David A. Cacchillo, D.D.S., M.S.
Joelle N. Stanger, D.M.D., M.S.
Muhammad Takriti, D.D.S., M.S.

614-861-8077
dental@periohealth.org

Patient Information

Name _____ Date _____

Referring Doctor _____

Radiographs _____ BW _____ PANO _____ Full Mouth _____ CT scan

_____ Radiographs emailed to **dental@periohealth.org**

_____ Mailed _____ Given to patient _____ Non Avail.

Reasons for referral

Periodontal Exam (area/s of concern)

Severity: _____ mild _____ moderate _____ severe

Extraction(s) # _____

Implant(s) # _____

Impressions taken for essix? Yes / No

Soft Tissue Graft # _____

Crown Lengthening # _____

Ridge Augmentation # _____

Exposure # _____

Oral Pathology (area of concern) _____

Other _____

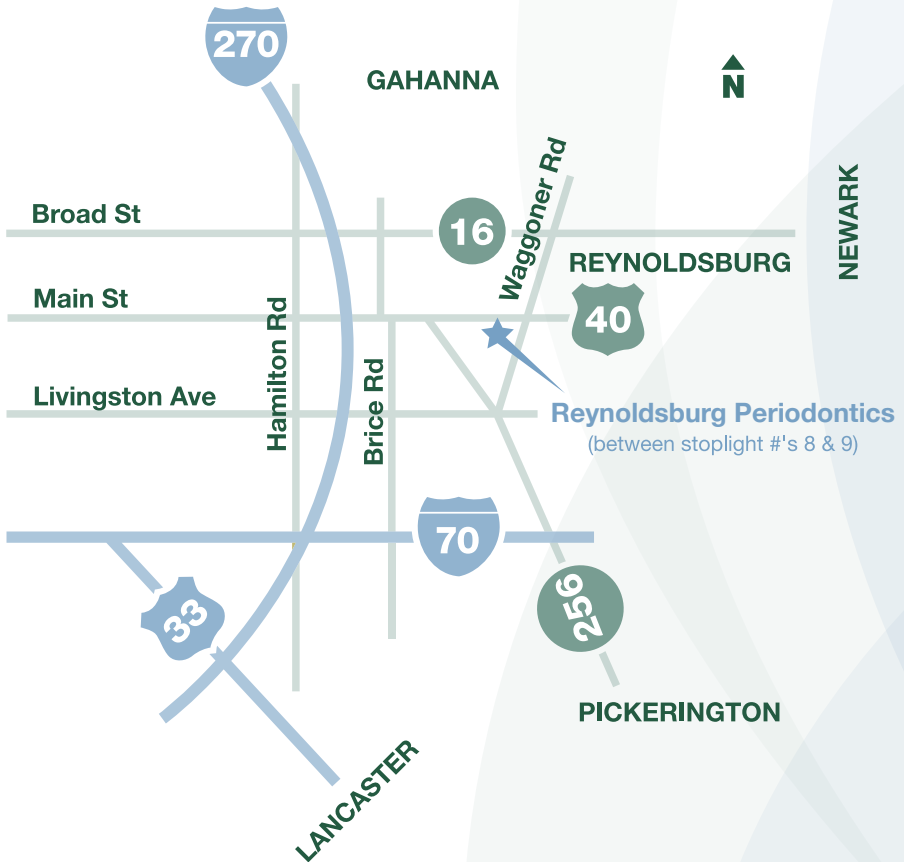
Comments _____

7535 East Main Street
Reynoldsburg, OH 43068
www.reynoldsburgperio.com





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