Reynoldsburg Periodontics
& Dental Implants

PATIENT REFERRAL SLIP

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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

Reynoldsburg Periodontics
& Dental Implants

270
GAHANNA
N
Broad St
16
Waggoner Rd
REYNOLDSBURG
NEWARK
Main St
40
Hamilton Rd
Livingston Ave
Brice Rd
Reynoldsburg Periodontics
(between stoplight #'s 8 & 9)
70
33
256
PICKERINGTON
LANCASTER

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