Audra Ward DMD, MS

ward
PERIODONTICS & IMPLANTS

PERIODONTAL REFERRAL FORM

Appointment Date	Time

Date _____

Patient's Name _____ **Phone** _____

Referring Doctor _____ **Phone** _____

REASON FOR REFERRAL *(select all that apply)*

- ☐ Comprehensive / Full Mouth Periodontal Exam
- ☐ Scaling and Root Planing
- ☐ Crown Lengthening, area(s) _____
- ☐ Dental Implant / Extraction with Socket Preservation, area(s) _____
- ☐ Frenectomy, areas(s) _____
- ☐ Exposure of Impacted Teeth, area(s) _____
- ☐ Periodontal Surgery, area(s) _____
- ☐ Recession, Soft Tissue Grafting, area(s) _____
- ☐ Sleep Medicine /Oral Appliance Therapy _____
- ☐ Other _____

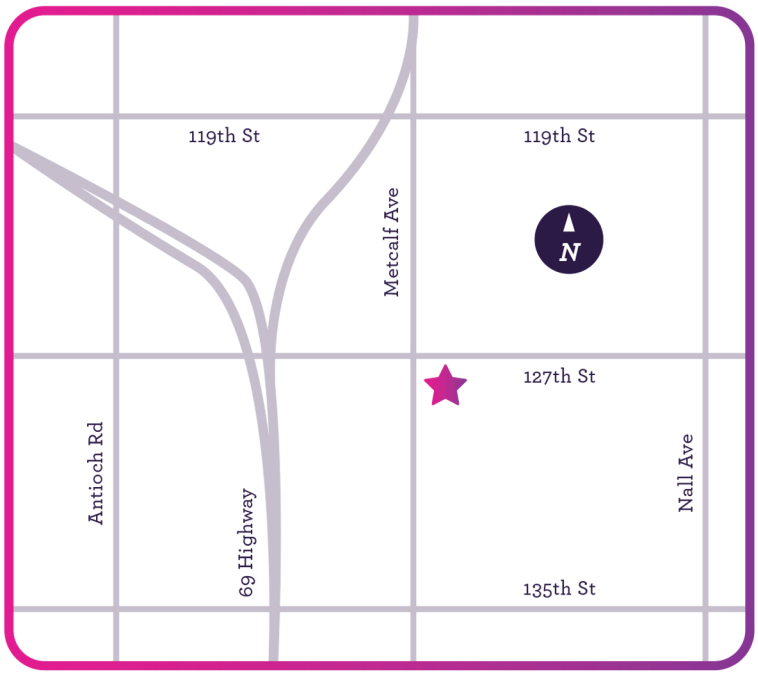
PERIODONTAL TREATMENT COMPLETED IN YOUR OFFICE

- ☐ Plaque Control Instructions
- ☐ Scaling and Root Planing, when _____
- ☐ Discussion About Periodontal Disease & Etiology
- ☐ Prophylaxis and / or Gross Debridement
- ☐ Peridontal Maintenance Therapy

RADIOGRAPHS

Please email all radiographs, including FMX, BWX and applicable PAs taken within the last two years to records@wardperio.com

COMMENTS



Active Member
American Academy of Periodontology

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Diplomate of The American Board of Periodontology, a recognized specialty of the American Dental Association