# San Diego Dental Specialty Center

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## Practice Limited To Periodontics and Dental Implant

☐ Must bring Referral
☐ Minor must be accompanied by parent or legal guardian

Patient Name:_____

Home Phone:_____ Work Phone:_____

Email:_____

Referring Office / Doctor:_____

Phone:_____

Appointment Date:_____ Time:_____

This patient is being referred for evaluation of:

( ) Comprehensive periodontal needs

( ) Implants and related services: #(s):

( ) Laser perio treatment:

( ) Periodontal needs limited to the area of #(s):

( ) Gingival recession / mucogingival surgery: #(s)

( ) Other:_____

To better serve your patient please provide the following information:

* Current full mouth radiographs (less than one year old)

( ) sent by email ( ) sent with patient

* Last periodontal recall visit was:_____

* Last root planning treatment:_____

* Anticipated restorative / orthodontic plans include:_____

If for any reason you cannot make this appointment, Please let us know at least 48 hours in advance