



LEXINGTON PERIODONTICS & IMPLANTOLOGY, LLC

Diplomates of the American Board of Periodontology

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PATIENT NAME: _____ DATE: _____

REFERRING DR: _____

REASON FOR REFERRAL: (Please fax/email this form upon patient referral)

[] Complete Periodontal Evaluation: _____

[] Crown Lengthening: MDFLP 360° Tooth no. (s) _____

[] Soft Tissue Consideration: Tooth no.(s) _____

[] Gingival Recession _____

[] Inadequate Attached Gingiva _____

[] Ridge Augmentation: Tooth no.(s) _____

[] Pontic Site _____

[] Edentulous for Future Implant Site: _____

[] Socket Preservation at Time of Extraction: _____

[] Maxillary Sinus Proximity: _____

Implant System Preferred: [] 3i [] Nobel Biocare [] Straumann [] Astra [] Zimmer [] Other

Table with 16 columns and 2 rows of tooth numbers (1-16 and 32-17).

PERIO PROSTHETIC EVALUATION:

[] Maxillary [] Mandibular

Perio Ortho Consideration: _____

[] Exposure of Impacted Teeth _____

[] PAOO (Corticotomy) _____

[] Frenectomy _____

Laser LANAP Periodontal Therapy

COMMENTS: _____

X-RAYS: [] given to patient [] will be sent by mail [] will be emailed [] FMX [] PANO [] CT

[] CBCT Cone Beam Computed Tomography

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