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BRADSHAW PERIODONTICS

Referring Doctor: _____ **Office Phone:** _____

I am referring: _____ to be evaluated for:

☐ Implant ☐ Crown Lengthening ☐ Frenectomy

☐ Periodontal Therapy ☐ Recession ☐ Tissue Grafting

☐ Other: _____

Patient Information:

Notes: _____

_____

_____

Please circle: Is patient? NEW or EXISTING

Hygiene Interval: 3-4 Months 6 Months 12 Months Sporatic

Has the patient received quadrant scaling and root planing? YES NO

If yes: Month: _____ Year: _____

UR UL

LR LL

X-rays :

Did patient have x-rays taken in your office that you can provide to us? YES NO (Circle)

If so, what kind of x-ray: _____ Date of x-ray taken: _____

We appreciate your staff sending these x-rays to us. By what method will x-rays be arriving from your office? (Check)

- ○ Email
- ○ US Postal Service
- ○ With patient

Are you requesting?

Cone beam CT (CBCT): YES ☐ **NO** ☐ If yes, area of concern: _____

Doctor's Preference for treatment:

Who will place abutment? ☐ Dr. Bradshaw ☐ Referring Doctor

Type of abutment preferred? ☐ Custom ☐ Standard

Do you wish for Dr. Bradshaw to do: ☐ Occlusal Adjustment ☐ Bite guard

Thank you for referring your patients to our office!