



DUY ANH TRAN, DMD
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 PERIODONTICS & IMPLANT DENTISTRY

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Referring Doctor: _____ Phone: _____ Date: _____

Introducing Patient: _____ Phone: _____

Pertinent Medical History: _____ (ie: Antibiotic Pre-Med): _____

APPOINTMENT:

- Made For Patient: Date: _____ Time: _____
- Patient instructed to call for an appointment: _____
- Please contact patient for appointment: Contact phone: _____

NATURE OF REFERRAL:

- Periodontal Disease
(Comprehensive Exam - FMX required)
- Biopsy
- Dental Implants
- LANAP *(Laser Assisted New Attachment Procedure - FMX required)*
- Other _____
- CT Scan
- Isolated Area (Teeth #s _____)
(Limited Exam-PA required)
- Recession/Mucogingival Defects
- Crown Lengthening
- Implant site preparation/ridge augmentation

AREA OF CHIEF CONCERN:

	A	B	C	D	E	F	G	H	I	J						
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
				T	S	R	Q	P	O	N	M	L	K			

RADIOGRAPHS:

- Were: mailed (date) _____ emailed (date) _____
 - Sent with patient
 - Please take
- For the most thorough diagnosis and treatment a recent FMX is requested.

Remarks or Special Instructions:

Tentative Restorative Treatment Plan: _____
