SPECIALIZED FAMILY DENTISTRY

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Patient Referral to:

Natalia Acosta-Farhadi DDS MS

Periodontist

Patient: _____ **Date:** _____

Referral by Dr. _____ **Phone:** _____

Reason for Referral:

☐ Complete periodontal evaluation _____

☐ Crown Lengthening for teeth #: _____

☐ Gingival Recession, teeth #: _____

☐ Oral Pathology: _____

☐ Dental implant #: _____ ☐ Orthodontic Exposure: _____ ☐ Frenectomy

☐ Extraction, tooth/teeth number: _____

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

Preferred implant system: ☐ Straumann ☐ Biohorizons ☐ Other:_____

Radiographs:

☐ With Patient ☐ FMX ☐ Mailed on: _____

☐ Pano ☐ E-mailed on: _____

☐ No X-rays ☐ CBCT

Prosthetic/restorative plans, comments, concerns, case description _____

_____