PERIODONTAL REFERRAL FORM

Date: __________________
Patient’s Name: __________________________________________________________ Phone: __________________
Referring Doctor: __________________________________________________________ Phone: __________________

REASON FOR REFERRAL: (select all that apply)
☐ Comprehensive/Full Mouth Periodontal Exam
☐ Limited Periodontal Exam, area(s): ____________________________
☐ Scaling and Root Planing
☐ Crown Lengthening, area(s): ____________________________
☐ Dental Implant/Extraction with Socket Preservation, area(s): ____________________________
☐ Abutment to be placed by: ☐ surgical dentist or ☐ restorative dentist
☐ Frenectomy and/or Fiberotomy, area(s): ____________________________
☐ Exposure of Impacted Teeth (canines), area(s): ____________________________
☐ Gingival Recontouring, area(s): ____________________________
☐ Periodontal Surgery, area(s): ____________________________
☐ Recession, Soft Tissue Grafting (graft for root coverage), area(s): ____________________________
☐ Other(s): ____________________________

RADIOGRAPHS:
☐ need to be taken ☐ patient will bring
☐ mailed ☐ e-mailed (xray@parkwaypg.com)

PERIODONTAL TREATMENT COMPLETED IN YOUR OFFICE:
☐ plaque control instructions ☐ prophylaxis and/or gross debridement
☐ scaling and root planing, when: ____________________________ ☐ periodontal maintenance therapy

COMMENTS:

Please enter on northeast side of the building. We have our own entrance below the Parkway Periodontal Group sign.

Dr. Julie K. Statz
Dr. Thomas A. Statz
Dr. Brandon K. Peterson
6600 Westown Parkway, Suite 170
West Des Moines, 50266
Phone: (515) 223-9700
Fax: (515) 224-7696
Email: XRAY@parkwaypg.com
www.parkwayperiodontalgroup.com