



INNOVATORS IN IMPLANT,
PERIODONTAL AND
PROSTHETIC DENTISTRY

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PERIODONTAL PATIENT REFERRAL FORM

410.548.1096

www.MyPerioSolutions.com

Referring Doctor: _____

Patient Name: _____

Please provide information and evaluation for the following conditions:

- Generalized periodontal disease.
- Localized, advanced bone loss, especially tooth # _____
- Receding gums.
- Loose teeth, occlusal trauma.
- Evaluation for dental implant surgery.
- Other _____

PATIENT STATUS:

- NEW CLIENT
- RETURNING CLIENT WITH:
 - New area(s) of concern.
 - Previously diagnosed and treated periodontal disease requiring further evaluation due to continued progression of the disease.
 - Initial periodontal therapy including scaling and root planning complete in all 4 quadrants.

DIAGNOSTIC INFORMATION:

In order to assist in the diagnosis, I have enclosed the following radiographs:

- Complete series
- Bitewings
- Panorex
- Single films
- I would like the above checked items to be returned to my office.

FOLLOW UP REQUEST:

- Please call my office to consult about patient care at the initial examination visit.
- Please send a written report of findings and plan of continuing care.

(OVER, PLEASE) →