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TSAI periodontics dental implants

1855 San Miguel Drive, Suite 10, Walnut Creek, CA 94596
Phone: (925) 944-1033, Fax: (925) 944-1039

Today's Date: _____

Patient's Name: _____

Patient's Phone: _____

Patient's Email: _____

Referred By: _____

Appointment Date: _____ Time: _____

REASON FOR REFERRAL:

- ❑ Comprehensive Periodontal Exam, Diagnosis, and Treatment
- ❑ Implant Consultation, Diagnosis, and Treatment
- ❑ Other: _____

PATIENT HISTORY:

- ❑ Maintenance Interval:
  - ❑ 3 month ❑ 4 month ❑ 6 months ❑ Sporadic
- ❑ Previous Periodontal Therapy:
  - ❑ None
  - ❑ Root Planning: Month: _____ Year: _____
  - ❑ Surgery: Year: _____ Area: _____

RESTORATIVE TREATMENT PLAN: _____

_____

ADDITIONAL INFORMATION: _____

_____

RADIOGRAPHS: *(An FMX, less than 3 years old is preferred)*

- ❑ We will email / mail an FMX before the examination appointment
- ❑ Please take a new FMX and email / return a set to me
- ❑ Patient will bring in an FMX

PLEASE RESPOND AS FOLLOWS:

- ❑ Letter
- ❑ Please call me to discuss the case

TOP - Patient Copy YELLOW - File Copy BACK - Mail or Fax Copy

THANK YOU FOR YOUR REFERRAL