JOHN T. SHEN, D.D.S.
PERIODONTICS & IMPLANT SURGERY

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PERIODONTAL REFERRAL

Patient Name: _____

Patient's Phone number: _____

Referring Doctor: _____

Referral Date: _____

Reason for Referral: ☐ Periodontal ☐ Implants

☐ Other: _____

Radiographs Available: ☐ FMX ☐ Bitewings ☐ Periapicals

☐ Panoramic ☐ CT ☐ None

Patient has Received: ☐ Prophylaxis / Periodontal Maintenance

☐ Scaling and Root Planing (Date: _____)

Special Comments: _____

_____

_____

Thank you for considering us for your patients' periodontal and surgical needs!