CONNECT PERIODONTICS AND IMPLANT DENTISTRY

Dr. Josh Shayefar, *DMD*
Board Certified Periodontist

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PATIENT'S NAME: _____

PHONE: _____ **DATE OF REFERRAL:** _____

- ☐ Comprehensive Periodontal Evaluation
- ☐ Dental Implant
- ☐ Dental Extraction and Bone Grafting
- ☐ Scaling and Root Planning
- ☐ Osseous Surgery/Pocket Reduction
- ☐ Gum Grafting for Recession
- ☐ Crown Lengthening
- ☐ Other: _____

PLEASE CIRCLE TEETH TO BE TREATED

Right	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	*Left*
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

CHIEF COMPLAINT: _____

RESTORATIVE TREATMENT PLAN AT <u>YOUR OFFICE</u>: _____

COMMENTS: _____

_____

- ☐ Our office will email x-rays to Info@cpidental.com
- ☐ Patient has no x-rays, please take what you will need.

PRACTICE NAME: _____ **OFFICE PHONE NUMBER:** _____

REFFERED BY DOCTOR: _____ **OFFICE EMAIL:** _____

We wanted to sincerely thank you and your patient for your trust in our office!