



3517 NW CAMAS MEADOWS DR, STE 200
 CAMAS, WA 98607
 PHONE (360) 818-2232 | FAX (360) 818-2261
 OFFICE@CAMASPERIO.COM

Referring Doctor: _____ Phone: _____ Date: _____

Introducing Patient: _____ Phone: _____

Pertinent Medical History: _____ (ie: Antibiotic Pre-Med): _____

APPOINTMENT:

Made For Patient: Date: _____ Time: _____

Patient instructed to call for an appointment: _____

Please contact patient for appointment: Contact phone: _____

NATURE OF REFERRAL:

- | | |
|--|--|
| <input type="checkbox"/> Periodontal Disease
<i>(Comprehensive Exam - FMX required)</i> | <input type="checkbox"/> CT Scan |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> Isolated Area (Teeth #s _____)
<i>(Limited Exam-PA required)</i> |
| <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Recession/Mucogingival Defects |
| <input type="checkbox"/> LANAP <i>(Laser Assisted New Attachment Procedure - FMX required)</i> | <input type="checkbox"/> Crown Lengthening |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Implant site preparation/ridge augmentation |

AREA OF CHIEF CONCERN:

			A	B	C	D	E		F	G	H	I	J				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		
			T	S	R	Q	P	O	N	M	L	K					

RADIOGRAPHS:

- Were: mailed (date) _____ emailed (date) _____ For the most thorough diagnosis and treatment a recent FMX is requested.
- Sent with patient
- Please take

Remarks or Special Instructions:

Tentative Restorative Treatment Plan: _____
