PERIODONTAL HEALTH PROFESSIONALS, LLC
The office of
Dr. Steve Flores
We Help Create Healthy Smiles

Steve Flores D.D.S., M.S
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512-872-4883

PERIODONTAL REFERRAL FORM

Patient Name: ____________________________ Phone No: ________________ Email: ______________________
Referring Doctor Name: ____ Phone No: ________________________
Address: ____

Reason for Referral

- ☐ Periodontal Evaluation Only
- ☐ Bone Graft
- ☐ Implant
- ☐ Osseous Surgery
- ☐ Crown Lengthening
- ☐ Gingivectomy
- ☐ Tissue Grafts
- ☐ Frenectomy
- ☐ Emergency Evaluation (problem focused)
- ☐ Other

Tooth #(s) ____________________ Quads: ________________________

Has the patient had previous periodontal therapy?

- ☐ None
- ☐ Prophylaxis Only
- ☐ Antimicrobial Therapy
- ☐ Scaling and Root Planning
- ☐ Surgery

Have you advised the patient of the possibility of extraction of any teeth? ○ Yes ○ No
If yes which teeth?

____

____

Does the patient require premedication? ○ Yes ○ No

Antibiotic used: ____

Radiographs:

☐ Please take/send copy ☐ Patient will bring copy ☐ I will send / Please return

Your Restorative Plans

____

Comments:

____

Please

☐ Call me before seeing the patient ☐ Call me after seeing the patient
☐ Alternate recare appointments ☐ Do all recare

General Dentist signature: ____ **Date:** __________________