825 Nicollet Mall
Suite 725
Medical Arts Building
Minneapolis, MN 55402
612-339-5593 • Fax 612-324-3136
info@downtownperio.com
Charles M. McCann, D.D.S., M.S.
Sam S. Atlasi, D.D.S., M.S

Patient Name: _____

DOB: _____ *Phone #* _____

Referral Information

I AM REFERRING THIS PATIENT FOR:

- ☐ *Complete Periodontal Evaluation & Treatment*
- ☐ *Isolated Periodontal Eval. & Treatment on #'s:* _____
- ☐ *Crown Lengthening Procedure on #'s:* _____
- ☐ *Recession/Grafting on #'s:* _____
- ☐ *Ridge Augmentation on #'s:* _____
- ☐ *Perio Surgery/Guided Tissue Regeneration:* _____
- ☐ *Implant Consultation on #'s:* _____
- ☐ *Other:* _____

RADIOGRAPHS ***(our office requires a complete series for perio evaluations)***

☐ *Recent radiographs (to be sent to our office): FMX* ☐ *date* _____, *Pano* ☐ *date* _____, *BWS* ☐ *date* _____

☐ *No recent radiographs (within last 5 years). New radiographs to be obtained in our clinic. We will send you the images.*

PREVIOUS Periodontal THERAPY:

- ☐ *Root Planing and Scaling* *(Areas:_____) (Date:_____)*
- ☐ *Surgery* *(Areas:_____) (Date:_____)*

Future Restorative Needs

- ☐ *Crowns on #'s:* _____
- ☐ *Bridges on #'s:* _____
- ☐ *Remove. prosth. (location):* _____
- ☐ *Caries on #'s:* _____
- ☐ *Restoration Replacement on #'s:* _____
- ☐ *Cosmetics/Veneers/Composites on #'s:* _____
- ☐ *Other:* _____

_____

_____

Please discuss the above restorative needs with the patient. ☐ *Yes* ☐ *No*

Case Planning

Case Planning Needed? ☐ *Yes* ☐ *No*

if yes:

- ☐ *Request a call BEFORE examination*
- ☐ *Request a call AFTER examination*

_____

_____

Dr. _____ *Date* _____