S.C. WALLACE, D.D.S., M.H.S.

Practice Limited to Periodontics
Implant Surgery •Oral Plastic Surgery

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Date: ______________________________ Patient: ______________________________

Home #: ______________________________ Work #: ______________________________

From Dr. ______________________________

REASON FOR REFERRAL

- ❑ Complete Periodontal Evaluation
- ❑ Limited Evaluation (area): ______________
- ❑ Crown Lengthening: # ______________
- ❑ Soft Tissue Graft: # ______________
- ❑ Expose/Bond: # ______________
- ❑ Implant Placement: area(s) ______________
- ❑ Ridge Augmentation: ______________
- ❑ Sinus Graft: ______________
- ❑ Biopsy (area): ______________
- ❑ Other: ______________

PERIODONTAL TREATMENT COMPLETED IN YOUR OFFICE TO DATE

- ❑ Plaque Control Instruction
- ❑ Root Planning-Date: ______________
- ❑ Prophylaxis/Gross Scale
- ❑ Perio Maintenance
  Frequency? ______________

IS THERE ANY RESTORATIVE DENTISTRY THAT NEEDS TO BE COMPLETED?

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CURRENT X-RAYS

- ❑ SENT BY MAIL
- ❑ SENT WITH PATIENT
- ❑ PLEASE TAKE X-RAYS

REMARKS OR SPECIAL INSTRUCTIONS:

OFFICE LOCATION