CHINOOK DENTAL GROUP

Date_____

Dr. Javier Cabrales
DMD, MDent Perio
Certified Specialist in Periodontology

Patient's Name_____

DOB_____ Phone Number_____

Email Address_____

Medical Alerts/Allergies/Concerns_____

_____

Referring Dentist

Name_____ Clinic_____

Email_____ Phone_____

Radiographs: ☐ Panoramic ☐ CBCT ☐ FMX ☐ BWs ☐ PAX

Reason for Referral:

- ☐ Comprehensive Periodontal Exam
- ☐ Specific Periodontal Exam
  - ☐ Restorative Crown Lengthening
  - ☐ Ridge Augmentation
  - ☐ Recession / Keratinized Tissue
  - ☐ Esthetic Crown Lengthening
  - ☐ Sinus Augmentation
  - ☐ Unerupted Tooth Exposure
  - ☐ Extraction
  - ☐ Other _____
- ☐ Implant Consultation Site(s)_____
  - ☐ Bone Level_____ ☐ Tissue Level (NN / RN / WN)

Internal Referral to additional Specialist(s) if recommended: ☐ Yes ☐ No

Comments:

Thank you for the confidence of your referral.

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