Saratoga Periodontics

(518) 587-7512 450 Maple Avenue, Saratoga Springs, NY 12866

Patient Referral Form

Please use this form to refer patients to our practice. Please contact our office if you would prefer that we send you a supply of carbonless referral forms.

Date: _______________

Patient Name: ____

Referred by Dr: ____

Reason for Referral:

- ☐ Periodontal Evaluation
- ☐ Implant(s)
- ☐ Gingival Augmentation/Grafting
- ☐ Occlusal Trauma and Mobility
- ☐ Biopsy
- ☐ Other ________________________

Specific Areas of Concern:____

Comments: ____

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Periodontal Treatment Previously Rendered:

- ☐ Hygienist Scaling/Root Planing Dates: ______________________________
- ☐ Scaling and Root Planing by Dentist Dates: ______________________________

Recall Interval:	☐ 3 mo.	☐ 4 mo.	☐ 6 mo.
Radiographs Forwarded:	☐ None	☐ PA/BW	☐ FMX/Pan

Please note: Radiographs older than 12-18 months are historical in nature. If required, current radiographs will be taken and a series will be returned for your records.