



PERIO HEALTH PARTNERS

Periodontal & Dental Implant Surgical Center

www.PerioHealthPartners.com • 585.376.5300

Date: _____

Referring Doctor: _____

Patient: _____

Referred to:

Mary Ann Lester, D.M.D.

- Appointment Scheduled on: _____
- Patient phone number to schedule: _____
- Patient will call to Schedule Appointment
- Please call before you see this patient
- Please call after you have seen this patient
- Please keep me informed by letter

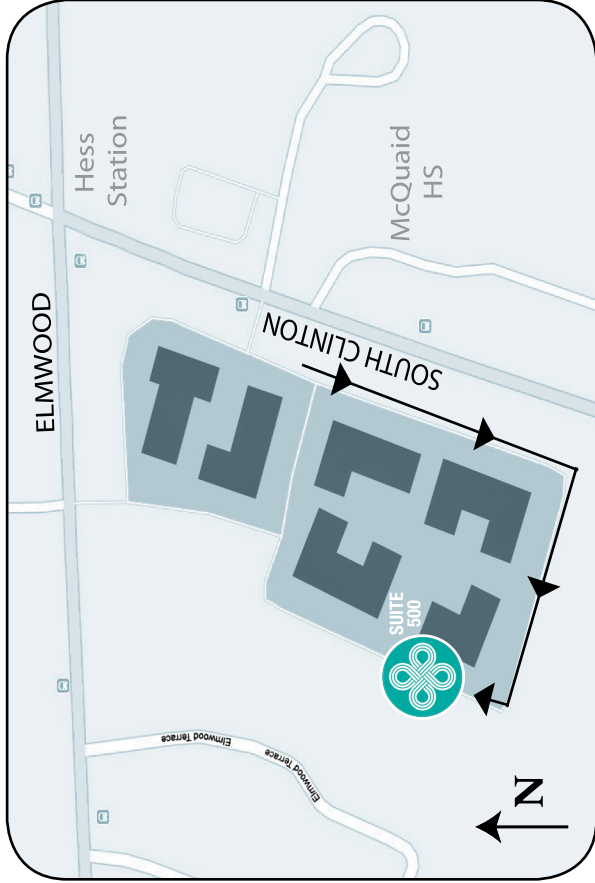
Radiographs:

- will be sent take at appointment
- do not return please return

- Please provide comprehensive/specific periodontal evaluation & treatment
- Patient has had scaling and root planing in the last 24 months
- Please provide implant evaluation for tooth/teeth #'s
- Please provide/evaluate for crown lengthening on tooth/teeth #'s
- Please evaluate for gingival recession of tooth/teeth #'s

UR 1 2 3 4 5 6 7 8	UL 9 10 11 12 13 14 15 16
LR 32 31 30 29 28 27 26 25	LL 24 23 22 21 20 19 18 17

Comments: _____



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