WELLNESS

Periodontology & Implantology Group

Josué Padilla DMD, MS, Ph.D.

1815 S. Clinton Avenue
Building 500 • Suite 500
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REFERRAL FORM

Referred by: ______________________________

Date: ______________________________

Patient Name: ______________________________

Home/Work/Cell: (______) ______ - ____________

Date of Appointment: __________ Time: ________ AM/PM

Tooth/Area to evaluate:

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

- ☐ Please provide comprehensive/specific periodontal evaluation & treatment
- ☐ Please provide implant evaluation for tooth/teeth #'s
- ☐ Please evaluate for gingival recession of tooth/teeth #'s
- ☐ The patient requires pre-med
- ☐ Please send additional referral cards
- ☐ Please evaluate:

____

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Please bring this form with you to your appointment.
Minors must be accompanied by a parent or guardian.

ELMWOOD AVE

ELMWOOD TERRACE

Speedway Station

SUITE 500

S. CLINTON AVE

MQuaid HS

N

W

E

S

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