SYNERGY PERIODONTICS

ELISA SIN, D.M.D. KALID HOSN, D.D.S

41250 12TH ST. WEST, STE. A

PALMDALE, CA 93551

TEL: (661) 267-0617 • FAX: (661) 267-0621

Date: _____

Introducing: _____

Referring Dr.: _____

Dr. Phone: _____

Email Address: _____

Appointment Date: _____ Time: _____

I AM REFERRING THIS PATIENT FOR:

- ❑ Implant Placement Evaluation
- ❑ Implant - Extraction & Placement Evaluation
- ❑ Include Final Implant Abutment
- ❑ Periodontal Eval. - Complete
- ❑ Periodontal Eval. - Limited
- ❑ Crown Lengthening
- ❑ Gingival Recession/Grafting
- ❑ Bone Grafting
- ❑ Other _____

AREAS OF CONCERN

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

PERIODONTAL TREATMENT DONE BY YOU

❑ Plaque Control & Oral Hygiene Instruction

❑ Root Planning & Scaling UR / UL / LL / LR / ALL Date Done: _____

RADIOGRAPHS:

- ❑ All being forwarded to you
- ❑ Are accompanying patient
- ❑ Are available in our office
- ❑ If needed, please take films and send me a set

RESTORATIVE THOUGHTS: _____

_____

_____

COMMENTS: _____

_____

_____

DOCTOR: _____

❑ Please send additional referral forms

Top Copy: To Patient Yellow: For Your Files

Patient: Please plan on arriving 15 minutes early to your first appointment for paperwork, as we all try to be on time to the best of our ability

★ **Our Office**