_____ *Anthony W. Gargiulo, D.D.S., M.S.*
_____ *Mark J. Gargiulo, D.D.S.*
Periodontics & Dental Implants
30 North Michigan Avenue, Suite 1904, Chicago, Illinois 60602
(TEL) 312-236-8514 (FAX) 312-372-1743
www.chicagoperiodontal.com

PATIENT: ______________________________ DATE: ______________

REFERRAL INFORMATION

APPOINTMENT:

- ☐ Please call patient for appointment Pat. Phone #: ______________________
- ☐ Patient will call your office for appointment.
- ☐ If the patient does not call within 14 days, please call him/her. ☐ Yes ☐ NO

I AM REFERRING THIS PATIENT FOR*:*

- ☐ Complete Periodontal Evaluation & Treatment.

On Teeth #s

- ☐ Isolated Periodontal Eval. & Txmt.
- ☐ Crown Lengthening Procedure
- ☐ Recession/Grafting
- ☐ GTR &/or Bone Grafting
- ☐ Implant Consultation
- ☐ Other:

RADIOGRAPHS:

- ☐ are enclosed. ☐ Last Full Series Taken On: ______________)
- ☐ are accompanying patient.
- ☐ are being forwarded to you: FMX____ # PA____ # BW____ # Other ______

PERIODONTAL TREATMENT COMPLETED IN OUR OFFICE

- ☐ Plaque Control & Oral Hygiene Instruction
- ☐ Root Planing and Scaling (Areas: ______________) (Date: ______________)

PREMEDICATION OR SPECIAL MEDICAL CONSIDERATION: ☐ No ☐ Yes

If Yes: ______________________________

RESTORATIVE NEEDS

- ☐ Crowns
- ☐ Bridges
- ☐ Remov. prosth.
- ☐ Caries
- ☐ Other

CASE PLANNING

☐ Please call BEFORE examination. ☐ Please call AFTER examination but before consult.

COMMENTS

DOCTOR: ______________________________

TOP - PATIENT COPY MIDDLE - REFERRING DOCTOR BOTTOM - MAILING CARD