Sasha Ross, DMD, MS
Diplomate of the American Board of Periodontology
Section of Dentistry

Date: _____

Patient Name: _____ **Patient Phone Number:** _____

Patient date of birth: _____

Referring Dentist: _____ **Dentist Phone Number:** _____

Reason for referral:

☐ Comprehensive periodontal examination _____

□ Localized periodontal examination (#: _____)

□ Periodontal (osseous) surgery (#: _____)

□ Gum recession (#: _____)

□ Gingivectomy/plasty(#: _____)

□ Crown lengthening (#:_____)

□ Extractions/site preservation (#: _____)

□ Implant(s) (#: _____)

□ Management of implant complications/peri-implantitis (#:_____)

□ Soft tissue biopsy (#: _____)

□ Other; please specify _____

Please email any current radiographs including recent full mouth series or panoramic films within the past 5 years to **dentalimages@ccf.org**. Please include the date that the x-rays were taken.

Please include quadrant(s) and dates of prior scaling/root planing.