Williamsburg Periodontics
& dental implants

FERNANDO MOGROVEJO, DDS, MS

PATIENT: _____ DATE: _____

DOB: _____ PHONE: _____

REFERRED BY DR: _____

REFERRED FOR:
- ○ **IMPLANT CONSULT, AREA(S) PLACEMENT** _____
- ○ **COMPREHENSIVE PERIODONTAL EXAM**
- ○ **SPECIFIC PERIODONTAL CONSULT, AREA(S)** _____
  - ○ CROWN LENGTHENING
  - ○ RECESSION/KERATINIZED TISSUE
  - ○ CUSPID EXPOSURE/FRENECTOMY
  - ○ ALVEOLAR RIDGE AUGMENTATION
  - ○ EXTRACTION/RIDGE PRESERVATION
  - ○ LASER THERAPY
  - ○ BIOPSY

RADIOGRAPHS: ○ SENT ○ PATIENT WILL BRING ○ NONE
○ TAKE FMX ○ TAKE CBCT

PATIENT MEDICAL HISTORY OR SPECIFIC CONSIDERATIONS:

_____

_____

ADDITIONAL COMMENTS:

_____

_____

_____

○ NEED MORE REFERRAL FORMS

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