Ryan J. Donovan, D.M.D., M.S.

Periodontics and Dental Implants

Diplomate of the American Board of Periodontology

Date ____________________

Patient ______________________ Tel# ____________________

Referring Dentist ______________________________________

Appointment Date I Time ______________________________________

I AM REFERRING THIS PATIENT FOR:

- ❑ Complete Periodontal Evaluation & Treatment
- ❑ Limited Periodontal Evaluation & Treatment
- ❑ Laser Periodontal Treatment
- ❑ Crown Lengthening
- ❑ Recession/Grafting
- ❑ Bone Regeneration
- ❑ Implant Consultation
- ❑ Ridge Augmentation
- ❑ Sinus Grafting
- ❑ Tooth Exposure
- ❑ Extractions
- ❑ IV sedation
- ❑ Other:

(Areas of Concern)

UR | UL | LL | LR | ALL

PERIODONTAL TREATMENT DONE BY REFERRING DENTIST:

- ❑ Root Planing and Scaling UR I UL I LL I LR I ALL Date Done ____________
- ❑ Frequent Periodontal Maintenance

RADIOGRAPHS:

❑ Are being forwarded to you ❑ Are accompanying patient ❑ Are available in our office

❑ If needed, please take films and send me a set

TREATMENT DISCUSSION: Please call me ❑ BEFORE ❑ AFTER your evaluation

RESTORATIVE TREATMENT PLAN/COMMENTS:

14361 Metropolis Avenue, Suite 3 • Fort Myers, Florida 33912
239-931-4141 • FAX 239-931-4140 • www.fortmyersperioimplants.com

White: Ryan J. Donovan, D.M.D., M.S. Yellow: Referring Dentist

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