KARL H. CHING, D.D.S., INC
STANLEY R. ROSS, D.D.S., PC
JEN LAI, D.M.D., M.S.
Periodontics and Dental Implants

299 Juana Avenue, Suite C
San Leandro, CA 94577
(510)352-6266
FAX (510)352-6392

Introducing _____ Phone #: _____

_____

Address City Zip

Please provide:

☐ A complete periodontal examination

☐ A limited periodontal examination (circle area/teeth)

Right	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Left
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

Evaluate for:

☐ Soft tissue graft ☐ Implants ☐ Crown Lengthening

☐ Periodontal Surgery: _____

☐ Emergency treatment: _____

☐ Prognosis/Treatment Planning: _____

_____

_____

Periodontal Treatment History:

History of **Scaling/Root Planing**: _____

History of Periodontal Surgery: _____

☐ You may proceed with treatment

☐ Please consult with me prior to initiating treatment

☐ Send additional referral slips

Xrays are: ☐ Mailed ☐ Sent with patient

☐ E-mailed ☐ Not Available

Appointment Date _____ Time _____

Referring Doctor: _____

Dr. Phone #: _____ Date _____

Pink – Referring Dr. Yellow – Patient's Copy White – Periodontist