EASTSIDE
PERIODONTICS | IMPLANTS

Benjamin Russell, DMD
Diplomate, American Board of Periodontology

Introducing: _____ Referred By: _____

Patients's Phone #: _____ Date of Referral: _____

RADIOGRAPHS

Date of Most Recent FMX/Pano: _____

☐ Films Mailed ☐ Films with Patient ☐ Please Take Films

☐ Radiographs e-mailed to gresham@eastside-perio.com

☐ Radiographs e-mailed to portland@eastside-perio.com

RESTORATIVE TREATMENT

☐ Is Planned ☐ Will Be Planned After Periodontal Evaluation

☐ Is Not Indicated

PERIODONTAL TREATMENT COMPLETED

Date Completed: _____

☐ Full Mouth Debridement

☐ Scaling and Root Planing

PLEASE EVALUATE FOR:

☐ Complete Periodontal Evaluation and Treatment

☐ Limited Periodontal Evaluation and Treatment

Areas of Involvement: _____

☐ Implant Evaluation and Treatment

Areas of Involvement: _____

COMMENTS:

_____

_____

_____

Appointment Date: _____ Time: _____

Select Location

☐ **Gresham**
742 NE Division, Ste 102
Gresham, OR 97030
503-667-2442

☐ **The Dalles**
1625 E 12th St.
The Dalles, OR 97058
541-296-6752

☐ **Portland**
2824 NE Wasco, Ste 230
Portland, OR 97232
503-954-1372

Please fax or email a copy of your referral to:

Gresham/The Dalles (503) 669-8876 gresham@eastside-perio.com Portland (503) 954-1392 portland@eastside-perio.com