EASTSIDE
PERIODONTICS | IMPLANTS

Benjamin Russell, DMD
Diplomate, American Board of Periodontology
Sei Kim, DMD

Introducing: _____ Referred By:_____

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

RADIOGRAPHS

Date of Most Recent FMX/Pano: _____

☐ Films Mailed ☐ Films with Patient ☐ Please Take Films

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

☐ Radiographs e-mailed to gresham@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

☐ Clackamas
10151 SE Sunnyside Rd, Ste 450
One Town Center, Clackamas, OR 97015
503-652-2615

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

Please fax or email a copy of your referral to:

Clackamas (503) 654-7561 contact@eastside-perio.com **Gresham** (503) 669-8876 gresham@eastside-perio.com