



NAPA VALLEY  
PERIODONTICS  
& DENTAL IMPLANTS

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Patient First Name: \_\_\_\_\_ Patient Last Name: \_\_\_\_\_

Date: \_\_\_\_\_ Patient Phone: \_\_\_\_\_ Referred By: Dr. \_\_\_\_\_

- Please call the patient to schedule
- The patient will call your office to schedule

**REASON FOR REFERRAL**

- |   |  |
|---|--|
| <input type="checkbox"/> Implant(s) Site(s): _____<br><input type="checkbox"/> Implant Placement<br><input type="checkbox"/> Extraction and Ridge Preservation<br><input type="checkbox"/> Ridge Augmentation / Sinus grafting<br><input type="checkbox"/> Straumann <input type="checkbox"/> Bicon <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Perio Evaluation Site(s): _____<br><input type="checkbox"/> Esthetic Procedures Site(s): _____<br><input type="checkbox"/> Gingival Recession<br><input type="checkbox"/> Contour Grafting<br><input type="checkbox"/> Esthetic Crown Lengthening |
| <input type="checkbox"/> Ortho Assist Site(s): _____<br><input type="checkbox"/> Thin Tissue/Gingival Recession<br><input type="checkbox"/> Expose and Bond   | <input type="checkbox"/> Biopsy / Oral lesions Site(s): _____<br><input type="checkbox"/> Crown lengthening Site(s): _____   |
- Other: \_\_\_\_\_

**PERIODONTAL TREATMENT ALREADY COMPLETED**

- |  |  |
|--|--|
| <input type="checkbox"/> Plaque Control and Instruction<br><input type="checkbox"/> Root Planing | <input type="checkbox"/> Prophylaxis and Gross Scaling<br><input type="checkbox"/> Periodontal Maintenance Therapy |
|--|--|

**COMMENTS**

**RADIOGRAPHS – Radiographs will be sent:**

- By Email
- By Mail
- Radiographs Required