NAPA VALLEY
PERIODONTICS
& DENTAL IMPLANTS

SEAN K. VREEBURG, DDS, MS

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

☐ Implant(s) Site(s): _____

- ☐ Implant Placement
- ☐ Extraction and Ridge Preservation
- ☐ Ridge Augmentation / Sinus grafting
- ☐ Straumann ☐ Bicon ☐ Other:

☐ Perio Evaluation Site(s): _____

☐ Esthetic Procedures Site(s): _____

- ☐ Gingival Recession
- ☐ Contour Grafting
- ☐ Esthetic Crown Lengthening

☐ Ortho Assist Site(s): _____

- ☐ Thin Tissue/Gingival Recession
- ☐ Expose and Bond

☐ Biopsy / Oral lesions Site(s): _____

☐ Crown lengthening Site(s): _____

☐ Other: _____

_____

PERIODONTAL TREATMENT ALREADY COMPLETED

☐ Plaque Control and Instruction

☐ Root Planing

☐ Prophylaxis and Gross Scaling

☐ Periodontal Maintenance Therapy

COMMENTS

RADIOGRAPHS – Radiographs will be sent:

☐ By Email

☐ By Mail

☐ Radiographs Required

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