LEXINGTON PERIODONTICS & IMPLANTOLOGY, LLC
Diplomates of the American Board of Periodontology

Zori Rabinovitz, D.M.D., M.S., C.A.G.S.
Manuel Molina, D.M.D., M.S.D., C.A.G.S.
Elias Exarchos, D.M.D., M.S.D., C.A.G.S.

PATIENT NAME: _____ DATE: _____

REFERRING DR: _____

REASON FOR REFERRAL: *(Please fax/email this form upon patient referral)*

❒ *Complete Periodontal Evaluation:* _____

_____

❒ *Crown Lengthening:* **M D F L P 360°** *Tooth no. (s)* _____

❒ *Soft Tissue Consideration: Tooth no.(s)* _____

- ❒ *Gingival Recession* _____
- ❒ *Inadequate Attached Gingiva* _____

❒ *Ridge Augmentation: Tooth no.(s)* _____

- ❒ *Pontic Site* _____
- ❒ *Edentulous for Future Implant Site:* _____
- ❒ *Socket Preservation at Time of Extraction:* _____
- ❒ *Maxillary Sinus Proximity:* _____

Implant System Preferred: ❒ *3i* ❒ *Nobel Biocare* ❒ *Straumann* ❒ *Astra* ❒ *Zimmer* ❒ *Other*

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

PERIO PROSTHETIC EVALUATION:

❒ *Maxillary* ❒ *Mandbibular*

Perio Ortho Consideration: _____

❒ *Exposure of Impacted Teeth* _____

❒ *PAOO (Corticotomy)* _____

❒ *Frenectomy* _____

Laser LANAP Periodontal Therapy

COMMENTS: _____

_____

_____

X-RAYS: ❒ *given to patient* ❒ *will be sent by mail* ❒ *will be emailed* ❒ *FMX* ❒ *PANO* ❒ *CT*

❒ CBCT Cone Beam Computed Tomography

33 Bedford Street, Suite 15
Lexington, MA 02420
Phone: 781-861-7777 • Fax: 781-861-0141
info@lexingtonperiodontics.com
www.lexingtonperiodontics.com

77 Great Road, Suite 206
Acton, MA 01720
Phone: 978-263-1313 • Fax: 978-264-4440
info@shgperio.com
www.shgperio.com

Forms can be downloaded from our websites