SHIMODA & BOYESEN PERIODONTICS, P.C.
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SERVICE WITH HONESTY & EXCELLENCE

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				A	B	C	D	E	F	G	H	I	J				
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
RIGHT	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LEFT
				T	S	R	Q	P	O	N	M	L	K				

Referring to Dr. _____

Introducing _____ **Phone #** _____

Address _____ **City/Zip** _____

Referred by _____ **Date** _____

Reason for Referral: _____

_____

____ **An appointment was made on** _____ ____ **Your office to call patient**
DATE

____ **Please call prior to examining patient** ____ **Patient will call**

Radiographs:

☐ **Patient will bring** ☐ **Return the radiographs**

☐ **Take as needed and send duplicates** ☐ **Keep the enclosed films for your records**

Periodontal therapy to date: _____

_____

Significant medical, dental history which may help: _____

_____

Comments / proposed restorative treatment: _____

_____