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 **north hills**  
**periodontics**

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**Charu S. Chandra, DMD, MDS**  
Dental Implants • Periodontics • Laser Therapy  
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PATIENT: \_\_\_\_\_

Work #: \_\_\_\_\_ Home #: \_\_\_\_\_

Cell #: \_\_\_\_\_ Email: \_\_\_\_\_

**I AM REFERRING THIS PATIENT FOR:**

- Complete Periodontal Evaluation
- Dental Implants
- Laser Therapy
- Limited Periodontal Evaluation
- Periodontal Cosmetic Evaluation
- CBCT
- Crown Lengthening
- Bone Regeneration
- Recession / Grafting / Frenum
- Orthodontic Surgical Exposure
- Other: \_\_\_\_\_

**(Areas of Concern)**

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

**PERIODONTAL TREATMENT COMPLETED:**

- Root Planning and Scaling UR / UL / LL / LR / ALL Date Done: \_\_\_\_\_
- Frequency of Periodontal Maintenance every \_\_\_\_\_ months

**RADIOGRAPHS:** (FMX \_\_\_\_\_ BWX \_\_\_\_\_ PA's \_\_\_\_\_ Pan \_\_\_\_\_)

- Are being forwarded to you.  Are accompanying patient.
- Are available in our office.  Take films as needed.

**RESTORATIVE RECOMMENDATIONS / COMMENTS:**

DOCTOR: \_\_\_\_\_ DATE: \_\_\_\_\_

White - Patient • Yellow - Referring Doctor