Kelley S. Thompson, D.D.S.

Practice Limited to Periodontics

8340 Mission Road Suite 203
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913-652-9844 phone
913-381-4286 fax

Periodontal Referral

Patient: _____ Age: _____

Date: _____ Referring Doctor: _____

Patient Information:

_____ New to Our Practice

_____ Been a Patent for _____ Years

_____ Regular Cleaning Every _____ Months

_____ Emergency Care Only

_____ Scaling and Root Planing: Date _____

_____ Medical Alert: _____

Request:

_____ Comprehensive Exam

_____ Limited Exam of _____

_____ Re-Evaluation After Scaling and Root Planing

_____ Specific Condition _____

Location

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

Radiographs:

_____ Take as Needed

_____ Keep Attached Radiographs for Your Records

_____ Please Return Attached Radiographs

Treatment Plan: Tentative Restoration Plan I am Proposing: _____

_____

Remarks _____

_____

_____ Please telephone me after seeing this patient

Kindly give 48 hours notice to change appointment.