



University of California  
San Francisco

UCSF PERIODONTAL SPECIALTY CLINIC  
707 Parnassus Ave, 3<sup>RD</sup> floor  
San Francisco, CA 94143-0753  
Phone: 415-476-1731  
Fax: 415-476-1563

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Phone Number: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Mailing Address: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Insurance ID#: \_\_\_\_\_

Diagnosis:

- Generalized health on reduced periodontium
- Mucogingival condition:
  - Lack of keratinized tissue
  - Recession
- Chronic gingivitis
- Localized mild/moderate/severe chronic periodontitis (circle one)
- Generalized mild/moderate/severe chronic periodontitis (circle one)
- Localized aggressive periodontitis
- Generalized aggressive periodontitis
- Refractory periodontitis
- Peri-implant mucositis
- Peri-implantitis
- Partial or complete edentulism
- Ridge deficiency (orthodontic or site development)

Other:

\_\_\_\_\_

Additional Information: \_\_\_\_\_ Preferred Implant system

\_\_\_\_\_ Request CBCT to be taken

Latest Radiographs: Date of last FMX/Panorex: \_\_\_\_\_

Other films on file/date: \_\_\_\_\_

CBCT date: \_\_\_\_\_

Please email referral and X-rays to: [perio.referrals@ucsf.edu](mailto:perio.referrals@ucsf.edu)

Referring Doctor Information: \_\_\_\_\_ Phone Number: \_\_\_\_\_