PERIODONTAL SPECIALTY CLINIC

University of California, San Francisco School of Dentistry
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Tel: (415) 476-1731
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Date:______________________

Patient's Name:____DOB:______________________

Phone Number:____

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 X-rays to perio.referrals@ucsf.edu

Referring Doctor:_______________________________________ Phone Number:_______________________