

PERIODONTAL COSMETIC ENHANCEMENT REFERRAL FORM

1436 Royal York Road, Suite 209, Toronto, Ontario, M9P 3A9
 Tel: (416) 243-5212 Fax: (416) 243-0655

Patient Name: _____ **Date:** _____

Patient Telephone #: _____ **Referred by Dr.:** _____

Significant Medical History _____

Does this patient require premedication? **NO** _____ **YES** _____

Reason patient originally presented for treatment at your office:

- | | |
|----------------------|------------------------|
| _____ Longer Teeth | _____ Ridge Deficiency |
| _____ Gummy Smile | _____ Recession |
| _____ Dental Implant | _____ Other _____ |

Final treatment will include: (List each tooth number after the appropriate treatment modality)

- | | |
|-----------------------------|-------------------------|
| _____ Bonded Restorations | _____ Porcelain veneers |
| _____ Direct bonded veneers | _____ Fixed bridges |
| _____ Other _____ | |

Periodontal procedures desired: (List each tooth number after the appropriate treatment modality)

Crown Lengthening

- a) Are the incisal edges in their final position? **YES** _____ **NO** _____
- b) Desired length of: **Central Incisors** _____ **Lateral Incisors** _____ **Cuspids** _____
- c) Which teeth will be restored following surgery? _____
- d) Special instructions: _____

Ridge Augmentation

- a) What type of provisional is planned? _____
- b) Is an ovate pontic planned? **YES** _____ **NO** _____
- c) Will an implant be placed into this area? **YES** _____ **NO** _____
- d) Special instructions: _____

Soft Tissue Graphs

- a) Is root coverage desired? **YES** _____ **NO** _____ Describe _____
- b) Special instructions: _____

Enclosures: _____ Signature: _____