BERKELEY PERIODONTICS & DENTAL IMPLANTS

☐ Ryan Horn, D.D.S.
☐ Barron Hong, D.M.D., M.S.
☐ Meetu Moody, D.D.S.
☐ Anand Maharathi, D.M.D.

REFERRING DOCTOR
PLEASE FAX BACK TO:
(510) 845-5128

Please press firmly

2999 Regent St., Suite 403 • Berkeley, CA 94705 • Tel. (510) 843-6341 • www.berkeleyperioimplants.com

Introducing: _____

Appointment has been reserved for: _____ (date) at _____ (time)

Reason for Referral:

- ☐ Complete Periodontal Examination and Treatment
- ☐ Evaluate Specific Area _____
- ☐ Gingival Recession _____
- ☐ Dental Implant _____
- ☐ Emergency Treatment _____
- ☐ Pre-Prosthetic Surgery (Ridge Augmentation & Crown Lengthening) _____
- ☐ CBCT Imaging _____
- ☐ Periodontal Endoscope _____
- ☐ Other _____

Recent Full Mouth Radiographs:

- ☐ Unavailable, Please Take New Radiographs
- ☐ Given to Patient
- ☐ Mailed to Your Office
- ☐ Emailed Xray to frontdesk@berkeleyperioimplants.com

Previous Periodontal Treatment:

- ☐ Prophylaxis and Gross Scaling
- ☐ Root Planing • Date of Service: _____
- ☐ Periodontal Maintenance Therapy: Every _____ Months for _____ Years

Comments: _____

Referred by: _____ Date: _____

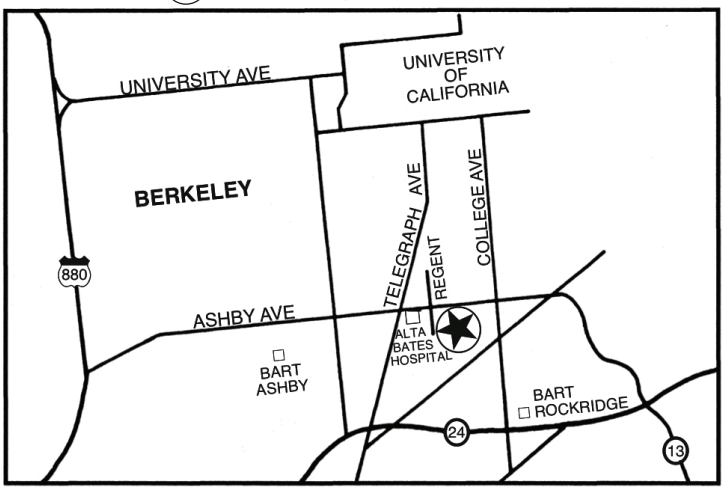
PATIENT INFORMATION

Welcome to Our Office!
Your doctor has referred you to our office for treatment of a periodontal (gum) problem. It is our goal to improve this situation as efficiently as possible, in a caring and supportive environment. If you do not have an appointment, please call us as soon as possible. Our entire staff looks forward to a pleasant, professional and personal relationship with you.

Emergency Care
Please notify us if there are any symptoms of pain, swelling, or discomfort. We will do everything possible to provide relief and comfort to you.

First Appointment
Your first appointment will consist of obtaining a thorough medical and dental health history, a complete mouth examination and the taking of x-rays if necessary. A description of the extent of your condition will be made as well as the diagnosis, estimated fee and time required for treatment. Please feel free to ask questions at any time!

2999 Regent Street, #403



White: Referring Dr. Copy (please fax) Yellow: Mail w/xray to Berkeley Periodontics Pink: Patient Copy