four corners periodontics, p.c.
mark s. blue, dds

Please email patient referral form to healthygums@drmarkblue.com

Patient Name:_____**Date of Birth:** _____

Patient Address:_____

Patient Phone #: _____**Email Address:**_____

Referring Doctor:_____**Date of Referral**_____

Referred for:

☐ **Gingival Recession:** Teeth #s _____
(Please send clinical photographs of involved area if possible)

☐ **Periodontal Disease:** Quads: UR LR UL LL. Individual Teeth #'s_____
(Please send any current radiographs and the most current periodontal charting)

Date of Previous SRP_____

☐ **Tooth Extraction:** #_____Reason for Extraction:_____

☐ **Dental Implants:** Missing teeth #'s_____
Date of tooth extraction(s)_____

☐ **Crown Lengthening:** Tooth #_____
(Please email x ray and clinical photograph if available)

☐ **Perio/Ortho:** Unexposed Tooth Uncovery: #_____Extract Primary Teeth #_____
(Please email Pano or send CBCT)

☐ **Other/Notes/Restorative Plans:**

Premedication: Yes☐ No☐ **Special Medical Considerations:**

Insurance Info:

Primary Subscriber:_____Date of Birth:_____Member ID_____

Insurance Company:_____ Group #_____

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