KENNETH ABE, D.D.S.
A Professional Corporation
Practice Limited to Periodontics
Microsurgery, Dental Implants
843 Altos Oaks Dr. #1, Los Altos, CA. 94024 (650) 941-2168

PERIODONTAL MICROSURGERY
DENTAL IMPLANTOLOGY

REFERRAL FORM

Patient: _____

Address _____
City: _____ Zip:_____

Pre-Med Required? ❒ No ❒ Yes Phone: ____ _____

Evaluation for:

❒ **Comprehensive Perio Exam**

❒ Treat as indicated
❒ Report before treating

❒ **Dental Implants**

Tooth # s _____

❒ **Emergency Treatment**
Tooth #'s _____

❒ **Limited Perio Evaluation**
Area/Teeth _____

❒ **Micro Lateral/Apical/Retrofill**
Tooth # _____

❒ **Micro/ Macro Fracture**
Tooth # _____

❒ **Micro-surgical Gingival Grafts**
Area _____

Perio Tx completed to date:

❒ Recall Maintenance
❒ Root Planing
❒ Surgery
When: _____
By Whom: _____
Type of Surgery: _____

Radiographs Available

FMX (< 3 yrs)
Date: _____

PA s Date: _____
BW s Date:_____

❒ We will take
❒ Please take
❒ Sent with patient

Please EM to drabe@microimplantdr.com

APPT DATE: _____

Time: _____
❒ Please Call Patient
❒ Patient will call you

❒ **Microsurgery - Minimally Invasive Periodontal Surgery**
Area's ❒ URQ ❒ UA ❒ ULQ
❒ LRQ ❒ LA ❒ LLQ

Comments / Special Instructions:

Referring Doctor: _____ **Date: _____**