Robert S. Carlish, DMD

PRACTICE LIMITED TO PERIODONTICS

A HEALTHY MOUTH FOR LIFE

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Patient:______________________________

Date:________________ Date of Appointment: ____________

Work #:__________________ Home #:______________

REFERRAL FOR:

☐ Complete Periodontal Exam
☐ Laser Periodontal Therapy
☐ Limited Periodontal Exam
☐ Crown Lengthening
☐ Bone Regeneration
☐ Recession I Grafting
☐ Emergency I Abscess

☐ Other: ______________________________

(Areas of Concern)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

PERIODONTAL TREATMENT DONE BY US ALREADY:

☐ Root Planing and Scaling UR / UL / LL / LR / ALL

Date Done:____________

RADIOGRAPHS: (FMX ____ BWX ____ PA's ____)

☐ Are being forwarded to you. ☐ Patient is bringing them.
☐ Are in our office. ☐ If needed, please take films and send me a set.

MEDICAL CONCERNS:

☐ PREMEDICATION ☐ Other ____________________

TREATMENT DISCUSSIONS: Please call me:

☐ BEFORE ☐ AFTER your exam.

COMMENTS I RESTORATIVE THOUGHTS:

DOCTOR:____________________ **DATE:**__________

TO REORDER MATERIALS:

Referral Slips ☐ Referral Brochure ☐ Hygene recall cards ☐

GRETNA
CHATHAM
HALIFAX
41
29
360
MARTINSVILLE
SOUTH BOSTON
58
DANVILLE
58
EDEN
57
ROXBORO
29
86
REIDSVILLE
YANCEYVILLE
41
29
29
BY-PASS
BUSINESS
29
PIEDMONT DRIVE
OFFICE
DAN RIVER
58
360
29
58
MAIN ST.
BUSINESS
W. MAIN ST.
S. MAIN ST.
86
BY-PASS
29
29

TO CHATHAM

Coleman MarketPlace

29

PINEY FOREST ROAD

OFFICE

PIEDMONT MALL

SHOPPING CENTER

HIGHLANDER

58 / RIVERSIDE DRIVE

TO SOUTH BOSTON

DAN RIVER

TO MARTINSVILLE

TO YANCEYVILLE