



RIVER CITY

PERIODONTICS AND IMPLANTS

Dr. Afnan Yousef, MS

140 Piney Forest Road, Suite 3 • Danville, VA 24540

(434) 793-1400 • Fax (434) 793-1401

info@danvilleperiodontist.com • www.danvilleperiodontist.com

Patient: _____

Date: _____ Date of Appointment: _____

Work #: _____ Home #: _____

REFERRAL FOR:

- Complete Periodontal Exam
- Laser Periodontal Therapy
- Limited Periodontal Exam
- Crown Lengthening
- Recession I Grafting
- Emergency I Abscess
- Extraction
- Bone Regeneration
- Implant
- 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:** _____

