MASS PERIO
DENTAL IMPLANT CENTER

Daniel Kao, DDS, MS, DMD
Harvard Clinical Faculty

PATIENT REFERRAL

Date..... Referring DR.....

Patient Name.....

This patient is being referred for an evaluation for the following:

- ☐ DENTAL IMPLANT THERAPY # _____
- ☐ EXTRACTION & BONE GRAFT # _____
- ☐ RIDGE AUGMENTATION / GBR # _____
- ☐ SOFT TISSUE GRAFTING # _____
- ☐ PERIODONTAL THERAPY
- ☐ CROWN LENGTHENING # _____
- ☐ TOOTH EXPOSURE # _____
- ☐ FRENECTOMY
- ☐ BIOPSY
- ☐ OTHER : _____

RADIOGRAPHS:

☐ Prior Radiographs are available (send to info@massperio.com)

☐ New Radiographs are needed

Restorative Plan and Comments_____
_____
_____

Please bring this form to your appointment

617-860-1180
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info@massperio.com

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