



MASS PERIO

DENTAL IMPLANT CENTER

Daniel Kao, DDS, MS, DMD
Harvard Clinical Faculty

PATIENT REFERRAL

Date mm/dd/yyyy Referring DR. _____

Patient Name _____

Patient Phone _____

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

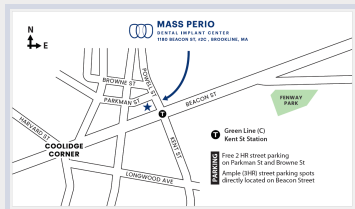
- | | |
|---|--|
| <input type="checkbox"/> DENTAL IMPLANT THERAPY # _____ | <input type="checkbox"/> CROWN LENGTHENING # _____ |
| <input type="checkbox"/> EXTRACTION & BONE GRAFT # _____ | <input type="checkbox"/> TOOTH EXPOSURE # _____ |
| <input type="checkbox"/> RIDGE AUGMENTATION / GBR # _____ | <input type="checkbox"/> FRENECTOMY |
| <input type="checkbox"/> SOFT TISSUE GRAFTING # _____ | <input type="checkbox"/> BIOPSY |
| <input type="checkbox"/> PERIODONTAL THERAPY | <input type="checkbox"/> 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



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