

Dr. M. Virginia Kirkland
NORTH POINT
 PERIODONTICS
 DENTAL IMPLANTS

Date of referral: ____/____/____ Referring Doctor: _____
 (Month) (Day) (Year)

Referring Hygienist: _____ General Practitioner: _____
 (If different from referral doctor)

Dr. Office Phone Number: _____

Introducing: Mr. Ms. Mrs. Dr. _____
 (Last) (First) (M.I.) (Preferred Name)

Home#: _____ Work#: _____ Cell#: _____

- Please Evaluate:**
- | | | |
|---|---|--|
| <input type="checkbox"/> Periodontal Condition | <input type="checkbox"/> Biopsy | <input type="checkbox"/> Frenulectomy and Fiberotomy |
| <input type="checkbox"/> Osseointegrated Implant Therapy | <input type="checkbox"/> Tissue Grafting | <input type="checkbox"/> Periodontal Maintenance Care |
| <input type="checkbox"/> Crown Lengthening, Tooth # _____ | <input type="checkbox"/> Recession | <input type="checkbox"/> Impacted Tooth Exposure |
| <input type="checkbox"/> Cosmetic Gingival Recontouring | <input type="checkbox"/> Periapical Abscess | <input type="checkbox"/> Endodontic/Periapical Surgery |
| | | <input type="checkbox"/> Laser Periodontal Therapy |

Special Problem Areas Limited To:

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

Other _____

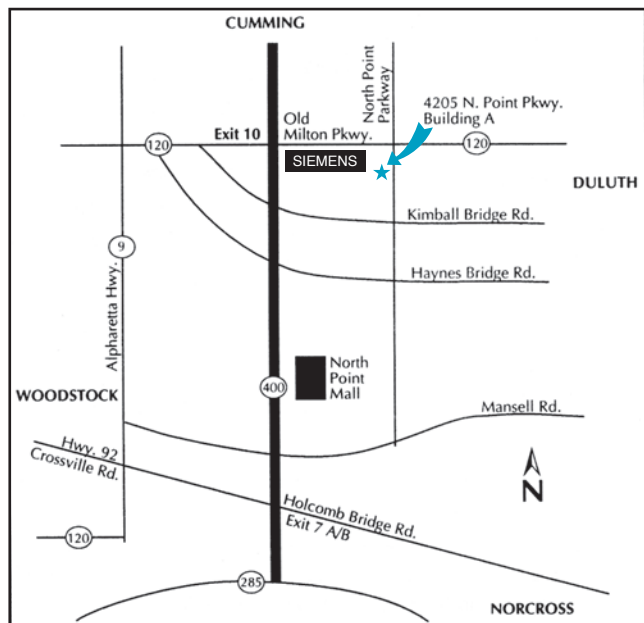
PLEASE CONTACT PATIENT TO SCHEDULE AN EXAMINATION APPOINTMENT.

Appointment:* Date: ____/____/____ Time: _____ A.M. _____ P.M.
 (Month) (Day) (Year)

*If unable to honor appointment please give courtesy of 48 hours notice: (770) 740-0442
 If you have dental insurance, be sure to bring your insurance card with you.

OUR OFFICE IS
 LOCATED AT:
 4205 North Point Pkwy.
 Building A
 Alpharetta, GA 30022
 (770) 740-0442

Please visit our
 website at
www.npperioimplants.com



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PLEASE PROVIDE THE FOLLOWING PERIODONTAL REFERRAL INFORMATION

Radiographs taken in the last 3 years: _____ PAN _____ FMX _____ PA _____ BW _____

Being sent with patient _____ Being mailed to us _____ Being emailed to us _____

Last Prophylaxis: _____ Last Scale/Root Planing _____

Major Restorative Treatment Planned/Completed: _____

Any Other Information: _____

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www.npperioimplants.com
office@npperioimplants.com

**PLEASE KEEP THIS COPY FOR YOUR RECORDS
 THANK YOU FOR YOUR REFERRALS**