SOUTH OKANAGAN PERIO
Periodontics and Implant Dentistry

Dr. Gurpal Buttar
Periodontist
BSc, DMD, MDent (Perio), FRCD(C)

Date: ______________________

Patient

Introducing: ☐ F ☐ M ______________________ D.O.B (D/M/Y): ______________________
Guardian: ______________________ Email: ______________________
Address: ______________________
City: ______________________ Postal Code: ______________________
Phone: (H)______________ (C) ______________ (W)______________
Dental History: *Recall Compliance* ______ years ☐ regular ☐ sporadic ☐ new patient
Medical History: ☐ Prophylactic Antibiotics Required

Insurance Information

Primary Insurance Carrier: ______________________
Policy Holder: ______________________ D.O.B (D/M/Y): ______________________
Group Policy #: ______________________ I.D. #: ______________________
Secondary Insurance Carrier: ______________________
Policy Holder: ______________________ D.O.B (D/M/Y): ______________________
Group Policy #: ______________________ I.D. #: ______________________

Reason for referral:

87654321	12345678
87654321	12345678

- ☐ Comprehensive Periodontal Exam & Treatment
- ☐ Specific Periodontal Exam
- ☐ Crown Lengthening
  - ☐ Esthetic
  - ☐ Functional
- ☐ Recession/Root Coverage
- ☐ Gingival Augmentation
- ☐ Crown Exposure(s)
- ☐ Frenectomy
- ☐ Fiberotomy
- ☐ TAD placement

- ☐ Implant(s)
  - ☐ Astra
  - ☐ Nobel
  - ☐ Straumann
  - ☐ Other______________
- ☐ Extraction(s) + Ridge Preservation
- ☐ Ridge/ Sinus augmentation
- ☐ Oral Pathology/Biopsy
- ☐ CBCT
- ☐ other______________

Radiographs/photos:
☐ sent with patient ☐ sent directly (mail/email) ☐ none available ☐ please return after use

Comments:

____
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Referred by Dr. ______________________ Phone: ______________________ Email: ______________________
(Please Print)

Please return this form by fax, email or mail to the address below.
Thank you for your kind referral

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