ATTLEBORO DENTAL GROUP

Dr. Justin Cifuni
Board-Certified Periodontist

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Patient Name _____ Patient Phone Number _____ Date _____

Referring Doctor _____ Referring Doctor Phone Number _____

Appointment Status: Date _____ Time _____ ☐ Or Patient Will Call to Schedule

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

Reason for Referral

- ☐ Generalized Periodontal Disease
- ☐ Localized Periodontal Disease # _____
- ☐ Implants # _____
- ☐ All-On-X _____
- ☐ Gingival Recession # _____
- ☐ Crown Lengthening # _____
- ☐ Frenectomy Max Mand # _____
- ☐ Extractions # _____
- ☐ Sedation Requested? _____
- ☐ Other _____

Periodontal Treatment Completed in Your Office

- ☐ Scaling/Root Planing Date: _____
- ☐ Perio Maintenance Date: _____

Please send recent radiographs.
PAs & BWs of the are, if possible.

Exposure Date: _____

Comments: _____

_____

_____

Please have your General Dentist complete this form and email it to our office at frontdesk@attleborodentalgroup.com.
If you do not have a general dentist, please call our office.

Scan for information on our providers and services: