Grand River Periodontics

Patient Referral Form

office@grandriverperio.com · (616) 531-1554 · 3050 Ivanrest Ave SW, Suite B, Grandville, MI 49418

Fill in and return by email to the address above, or attach to a fax cover sheet.

Patient name

Date of birth

Patient phone number

Referral date

Referring doctor

Referring office phone

Treatment requested (check all that apply)

- ☐ Comprehensive periodontal exam
- ☐ Dental implant therapy
- ☐ Gingival / esthetic crown lengthening
- ☐ Extraction
- ☐ Recession / gingival grafting
- ☐ Restorative crown lengthening
- ☐ Frenectomy
- ☐ Soft- or hard-tissue lesion / biopsy

Other

Scaling and root planing completed? ☐ Yes ☐ No

Date of treatment (if applicable)

Additional notes

Radiographs / images: attach if available, or email separately to office@grandriverperio.com.