



LEXINGTON PERIODONTICS & IMPLANTOLOGY, LLC

Diplomates of the American Board of Periodontology

Zori Rabinovitz, D.M.D., M.S., C.A.G.S.
Manuel Molina, D.M.D., M.S.D., C.A.G.S.
Elias Exarchos, D.M.D., M.S.D., C.A.G.S.

PATIENT NAME: _____ DATE: _____

REFERRING DR: _____

REASON FOR REFERRAL: (Please fax/email this form upon patient referral)

- Complete Periodontal Evaluation: _____
- Crown Lengthening: **M D F L P 360° Tooth no.(s)** _____
 - Gingival Recession _____
 - Inadequate Attached Gingiva _____
- Ridge Augmentation: Tooth no.(s) _____
 - Pontic Site _____
 - Edentulous for Future Implant Site: _____
 - Socket Preservation at Time of Extraction: _____
 - Maxillary Sinus Proximity: _____

Implant System Preferred: Straumann Nobel BioCare 3i Astra Zimmer Other

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

PERIO PROSTHETIC EVALUATION:

- Maxillary Mandibular

Perio Ortho Consideration:

- Exposure of Impacted Teeth _____
- PAOO (Corticotomy / SFOT) _____
- Tads (MSE/ MARPE) _____
- Frenectomy _____

Laser LANAP Periodontal Therapy / Laser Assister Therapy

COMMENTS: _____

X-RAYS: given to patient will be sent by mail will be emailed FMX PANO CBCT

33 Bedford Street, Suite 15
Lexington, MA 02420
Phone: 781-861-7777 ● Fax: 781-861-0141
xrays@lexingtonperiodontics.com
www.lexingtonperiodontics.com

77 Great Road, Suite 206
Acton, MA 01720
Phone: 978-263-1313 ● Fax: 978-264-4440
info@lpiofActon.com
www.lpiofActon.com