Tyler Kim DDS & Tat Chiang DMD

Diplomate of American Board of Periodontology

Date: _____

Referring Doctor (s): _____

Patient: _____ Patient Phone: _____

Evaluations:

_____ Full mouth periodontal evaluation and treatment
_____ With special concern on: #_____
_____ Isolated Area only #_____
_____ Crown Lengthening procedure #_____
_____ Mucogingival surgery (recession)
_____ Root Coverage #_____
_____ Increase Attached Gingiva #_____
_____ Ridge Augmentation on the area
_____ with extraction(s) #_____
_____ Frenectomy #_____
_____ Fibrootomy #_____
_____ Gingivectomy #_____
_____ Implants #_____
_____ Other _____

Previous periodontal therapy performed:

_____ Phase 1 S/RP, _____ Surgery Dates: _____
Radiograph (FMX _____ PAs: _____)
_____Email _____Being brought by Patient.

Please kindly send completed referral forms via fax to (908) 218-9789 or email at smile@kandcperio.com.
Thank you for trusting us with your patient.

Please bring available X-rays and insurance card(s)

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Somerville, NJ 08875
www.kandcperio.com

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F: (908)218-9789
E: smile@kandcperio.com