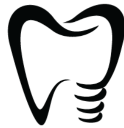

SETH RUSH, DDS, MS

PERIODONTICS & DENTAL IMPLANTS

9249 Ward Parkway, Kansas City MO 64114

TEL: (816) 444-8822 | Fax: (816) 444-0492

Please allow me to introduce my patient for periodontal evaluation.

Date: ______________ **Patient's Name:** ______________________________________

Patient's Contact Information:

Home: (_____)__________________ Work/Cell: (_____)____________________

My findings indicate a need for:

- ☐ Periodontal Consult
- ☐ Emergency Care
- ☐ Periodontal Consult & Crown Lengthening Tooth #________________
- ☐ Implant Consult Site #__________________
- ☐ Bone Grafting Consult Site #__________________
- ☐ Soft Tissue Grafting Tooth #________________

Radiographs: ☐ Have been mailed ☐ Have been sent with patient

☐ Have been emailed to mail@rushperio.com

☐ May be taken in your office & a copy sent for our records

Type: ☐ Bitewing x-rays ☐ Full mouth survey ☐ Pano

Insurance:

- ☐ Patient has dental insurance Company: __________________________
- ☐ Patient has no dental insurance

Initial Periodontal Therapy (Scaling/Root Planing):

- ☐ Patient has had initial therapy Date(s):________________
- ☐ Patient has not had initial therapy

Comments: ____

____

____

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☐ We have scheduled an appointment with your office on________________at__________AM/PM

☐ We have requested our patient contact your office at their earliest convenience.

__________________________________ __________________________

Referring Doctor (Please Print) Phone Number