Date______________________

Dear Doctor _____________________

Your patient , , has been treated for periodontal condition which existed when you made referral to our office.

The patient has been instructed to return to your office for any necessary dental care. We would like to arrange continuing check on his/her periodontal condition. Periodontal maintenance with us has been set for . We would like to alternate recalls on a month basis. Please schedule this patients return to your office for a prophylaxis and examination on . To aid your scheduling, we have advised the patient that your office will contact them for an appointment.

An outline of this patient's periodontal therapy is indicated below:

( ) Scale and Polish
( ) Root Planning
( ) Oral Hygiene Instructions
( ) Occlusal Adjustment
( ) Night Guard Appliance
( ) Minor Tooth Movement
( ) Curettage
( ) Implant
( ) Crown Lengthening
( ) Transseptal Fiberotomy
( ) Root Amputation
( ) Gingivoplasty, Gingivectomy
( ) Laser "LANAP"

( ) Flap
( ) Osseous Surgery
( ) Bone Fill
( ) Osseous Graft
( ) Guided Tissue Regeneration
( ) Ridge Augmentation
( ) Removal of Exostosis
( ) Mucogingival Surgery
( ) Gingival Graft
( ) PedicleGraft
( ) Hemisection
( ) Subepithelial Connective Tissue Graft
( ) Other

16	15	14	13	12	11	10	9	I	8	7	6	5	4	3	2	1
L	—	—	—	—	—	—	—	I	—	—	—	—	—	—	—	R
17	18	19	20	21	22	23	24	I	25	26	27	28	29	30	31	32

Remarks:
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