Niloofar Zarkesh, D.D.S., M.S., Diplomate of the American Board of Periodontology

Perio4U

386 South Monroe St.
San Jose, CA 95128
www.perio4u.com

Tel: (408) 998-8008
Fax: (408) 998-9009
doctor@perio4u.com

Fax Referral Form - No Cover Sheet Required
Please Fax to (408) 998-9009

This is to Introduce Mr. / Ms. _____ to your office.

Patient Phone # (Mobile) _____ (Work) _____ (Home) _____

Referring doctor_____ Phone _____ Date _____

Areas of Concern _____

Suggested Treatment:
___Comprehensive periodontal evaluation and treatment
___Limited oral evaluation and treatment of sites: _____
___Crown lengthening _____
___Dental Implants _____
___Esthetic periodontal evaluation and treatment
___Consult only
___Other _____

Radiographs: Please give a copy of the most recent radiographs to your patient for their initial visit or e-mail them to us at xray@perio4u.com.
___ The following are available: _____
___No new radiographs available, please take

Scaling & Root Planing:
___Has been performed on _____
___Will be performed on _____
___Please perform at your office
___Only recall was done on _____

Restorative Treatment Plan:
___Is complete
___Is established
___Is pending outcome of periodontal consult
Treatment plan: _____

Scheduling:
___Patient is scheduled in your office on _____, and Time _____
___Patient would like you to call and make an appointment as soon as possible.
___Patient will call your office to schedule an appointment. If patient did not call please call and schedule in a week.

Additional Information:
_____
_____
_____
_____

Thank you for giving us the opportunity to be part of your patient's dental care.