Niloofar Zarkesh, DDS, MS, Christine Hayashi, DDS, MS, Adrienne Gunstream, DDS, MS,

Perio4U
Periodontics and Dental Implants Center

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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

Please select the doctor you want your patient to see:

_____ Dr. Niloofar Zarkesh, DDS, MS

_____ Dr. Christine Hayashi, DDS, MS

_____ Dr. Adrienne Gunstream, DDS, MS

_____ Please schedule with first available doctor

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

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

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 it to us at xray@perio4u.com.
___Prior Radiographs are available upon request
___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 day _____, Date_____, 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.