James D. Spivey, D.D.S., M.S.

BOARD CERTIFIED IN PERIODONTICS
DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY
DIPLOMATE OF THE AMERICAN BOARD OF ORAL IMPLANTOLOGY / IMPLANT DENTISTRY
FELLOW OF THE AMERICAN ACADEMY OF IMPLANT DENTISTRY

~

Preventative Periodontal Care ~ Intravenous Sedation ~ Dental Implants

Patient Information:

Introducing: _____ DOB: _____

Address _____
Street Address City State Zip Code

Phone #: (H) _____ Work/Mobile _____

Extent of Clinical Problem: ☐ **General Evaluation** ☐**Localized Evaluation**

☐ Please √ if patient must premedicate:

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

Referred for:

□ **Periodontal Treatment**	□ Scaling and Root Planning Completed? Date:_____
□ Comprehensive Periodontal Charting	□ Gingival Grafting (attached tissue/Root Coverage)
□ Gingival Biopsy	□ Diagnosis and/or Treatment of Periodontal Disease(s)
□ Interdisciplinary Treatment Planning	□ Crown Lengthening (Biologic Width)
□ Esthetic Zone Crown Lengthening	□ Guided Tissue Regeneration (Vert. Defects, Furcas)
□ Pericornitis (Chronic/Acute)	□ Ridge Augmentation (Pontic Site Development)
□ Periodontal Flap/ Osseous Surgery	□ Abscess
□ Recession	□ Other (note comments Below)

□ **Dental Implant Therapy &/or Other Treatment (please indicate teeth involved above)**
□ **Implant Therapy Only** (Indicate Location(s) on above Diagram)
□ Implant(s) in conjunction with periodontal management of adjacent teeth
□Tooth Extraction (TE) & Immediate Implant Placement or □(TE) and Socket Retention/Devel.(Gingival/Osseous)
□Implant Plus (□Transfer coping □Analog □Stock Abutment □Custom Abutment □Provisional Crown) Please √
□**Orthodontic Implant Placement** □Orthodontic Tooth Exposure, Bracketing, and Gingival Management

Appointment Information:

□ Dr. Spivey's Office to call patient □ Patient will call □ Patient Appointed Date: _____ Time: _____

The following information is requested for ALL patients being referred. Please indicate below how this information will be sent.

Refferral Slip: □ Emailed □Mailed □ Faxed **Radiographs:** *Dated* _____□ Emailed □Mailed □ Faxed

Periodontal Charting: *Dated* _____□ Emailed □Mailed □ Faxed

Additional Comments: _____

_____

Doctor's Signature _____ **Date:** _____

Once patient has appointed with our office, directions will be mailed to them withour new patient packet. All forms, directions and contact information can also be found on our website www.drspivey.com

278 Lafayette Road, Bldg. E. Portsmouth, NH 03801 ~ Phone: (603)436-7787 ~ Fax: (603)430-8597
Email Address: Info@drspivey.com ~ Website: www.drspivey.com