ADVANCED
PERIODONTAL
PROFESSIONAL (A.P.P)
Mobile Dental Services

Dr. Saeid Malboubi
Periodontist

Periodontal Referral Form

Periapical X-ray Enclosed:

Date: _____ Office: _____

Patient name: _____ Improvise Account: _____

Patient Phone: _____ Provider: _____

Referring Doctor: _____ Medical: _____

Insurance: Dental: _____ Note: _____

Medical Insurance information neededPayment/Benefits may be optional for the patient under medical insurance **(Include Copy of Medical Card)**

DIAGNOSIS

1. **Periodontal Disease**
   - ☐ **TYPE I – Gingivitis**
   - ☐ **TYPE II – Early Periodontitis** Generalized☐ Localized☐
     Slight bone loss;no mobility/furcas; pockets 4-6mm
   - ☐ **TYPE III – Moderate Periodontitis** Generalized ☐ Localized☐
     Noticeable bone loss;pockets 6-7mm
   - ☐ **TYPE IV -Advanced Periodontitis** Generalized ☐ Localized☐
     Mobility; furcas; bone loss pocket >8mm
   - ☐ **TYPE V – Refractory Progressive Periodontitis** Generalized ☐ Localized ☐
2. Recession _____
3. Pre-pr4osthetic/restorative (Please specify so I can reinforce recommended treatment to your patient to increase compliance.)
4. Diagnostic (unknown lesions)
5. Other

MEDICAL HISTORY COMPLICATION FACTORS

- ☐ Diabetes
- ☐ Immune Disorder
- ☐ Cancer
- ☐ Does the patient need premedication?
  - ☐ Yes (if yes please advise patient to take premedication prior to appointment)
  - ☐ No

☐ Other (specify)
☐ Cardiac Disease
☐ Bleeding Disorder

DENTAL HISTORY

1. Previous Perio surgery Date: _____ Periodontist: _____ Area: _____

For office locations please visit www.drmalboubi.com or contact
949.468.7744 – 949.200.0600