Beth A. Gold, D.D.S.

Practice Limited to Periodontics and Implantology
5100 Grove St., Suite A, Marysville, Washington 98270
360-659-6732 • 1-800-876-GUMS • FAX: 360-653-6835
www.bethagolddds.com • Dr. Gold Email: bethagolddds@icloud.com
Referral & X-ray Email: scheduling@bethagolddds.com

Introducing _____ Date _____

Referred by Doctor _____

Patient Home Phone _____ Patient Work Phone _____

Type of Periodontal Evaluation Requested:

- ☐ Comprehensive Periodontal Examination.
- ☐ Limited Periodontal Examination
  Location and Nature of Problem _____
- ☐ Dental Implants _____
- ☐ Mucogingival problems (e.g. gingival grafts, frenectomy)
- ☐ Full-mouth radiographic survey enclosed
- ☐ Please take new radiographic survey and remit copy

Optional Information

Restorative Needs: ☐ Maxillary denture required
☐ No restorative needs ☐ Your restorative suggestion appreciated
☐ Restorative needs to be reinforced _____

Referring Doctor's Preferences:
I would prefer: ☐ A telephone call prior to the exam on my patient.
to do my own: ☐ Ext. ☐ Endo. ☐ Ortho.
to refer patient for: ☐ Ext. ☐ Endo. ☐ Ortho.
you refer patient for: ☐ Ext. ☐ Endo. ☐ Ortho.

Doctors Comments: _____

"A Foundation for Health"