



UNIVERSITY OF WASHINGTON

Department of Periodontics
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<https://dental.washington.edu/periodontics/>

HIPAA requires using encrypted email pathways when emailing patient information.

*Please consult our [referral email policy](#)

Introducing: _____ DOB: _____ ☐ Premed
Request: _____
Address: _____ City: _____ Zip: _____
Home: _____ Work: _____ Mobile: _____
☐ Patient will call ☐ Please call patient for appointment
Referring doctor(s): _____ Date: _____
Ref Doc Address: _____ Ref Doc Tel: _____
Ref Doc Email: _____ Ref Doc Fax: _____

☐ Comprehensive examination (multiple sites) ☐ Limited Exam
☐ Conscious Sedation Requested ☐ Gingival recession
☐ Perio Disease ☐ Implants ☐ Crown lengthening ☐ Esthetic concerns

Areas of Concern:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Preferred Implant System: _____

Anticipated Restorative Treatment Plan following completion of Periodontal Therapy:

Additional Information:

Past Root Planing date: _____ Past Maintenance Frequency: _____

The Graduate Periodontics Clinic is not an Applecare provider but we are happy to see Applecare patients on a self-pay basis.

Radiographs

☐ Radiographs enclosed ☐ Email to orad@uw.edu ☐ Take new radiographs
☐ FMX w/ Bitewings ☐ Bitewings ☐ Periapical(s) ☐ PAN ☐ CT Scan