University of California
San Francisco

UCSF PERIODONTAL SPECIALTY CLINIC
707 Parnassus Ave, 3RD floor
San Francisco, CA 94143-0753
Phone: 415-476-1731
Fax: 415-476-1563

Patient's Name: _____ Date: _____

Patient's Phone Number: _____ DOB: _____

Patient's Mailing Address: _____

Insurance Name: _____ Insurance ID#: _____

Diagnosis:

___Generalized health on reduced periodontium

___Mucogingival condition:

___Lack of keratinized tissue

___Recession

___Chronic gingivitis

___Localized mild/ moderate/ severe chronic periodontitis (circle one)

___Generalized mild/ moderate/ severe chronic periodontitis (circle one)

___Localized aggressive periodontitis

___Generalized aggressive periodontitis

___Refractory periodontitis

___Peri-implant mucositis

___Peri-implantitis

___Partial or complete edentulism

___Ridge deficiency (orthodontic or site development)

Other:

_____

Additional Information: _____Preferred Implant system

_____Request CBCT to be taken

Latest Radiographs: Date of last FMX/Panorex: _____

Other films on file/date:_____

CBCT date:_____

Please email referral and X-rays to: perio.referrals@ucsf.edu

Referring Doctor Information: _____ Phone Number: _____