REFERRAL REQUEST

- JUSTIN ZALEWSKY, DMD, MS
- ANTARA DARU, DDS, MS
- VIDUSHI GUPTA, DMD, MS
- WALEED ALKAKHAN, DDS, MSD, MA
- DIMA LAKKIS, DMD, MS
- KENNETH TANG, DMD, MS

PRECISION

Periodontics and Implant Dentistry

ALEXANDRIA, VA:
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Reston, VA 20190
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WASHINGTON, DC:
2311 M Street NW
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202-296-3360

INFO@PERIODMV.COM
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Referring Doctor_____ Date_____

Mr./Mrs./Ms./Dr._____

is being referred to you for periodontal examination.

Phone_____ Email _____

THE FOLLOWING CONDITION(S) ARE OF CONCERN:

○ Generalized periodontitis_____

○ Localized periodontitis (teeth) _____

○ Mucogingival defect, recession (teeth) _____

○ Crown lengthening (teeth)_____

○ Edentulous ridge augmentation (area) _____

○ Extractions and ridge augmentation _____

○ Endosseous implant _____

○ Other condition_____

COMMENTS:

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