Jin Y. Kim, DDS, MPH, MS
Perio Touch
Periodontics & Dental Implants

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REFERRAL FOR PERIODONTAL CONSULTATION & TREATMENT

Please direct referral to:

☐ **Jin Y. Kim**, DDS, MPH, MS
☐ **Roy Yoo**, DMD
☐ either specialist

Introducing_____ Phone No._____

Appointment Date _____ Time_____

My patient requires:

☐ Complete periodontal examination
☐ Limited periodontal examination (please indicate areas of concern)
☐ Crown lengthening procedure (please indicate areas of concern)
☐ Dental implant evaluation
☐ Restorative/prosthetic recommendations

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

PLEASE INDICATE AREA OF CONCERN

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

I have performed:

☐ Scaling and root planing (indicate quadrants & dates)
☐ Routine proplylaxis
☐ Occlusal adjustment
☐ Restorative treatment (indicate)

Future restorative plan is as follows:

Radiograph(s) available & Date: ☐FMS ☐BW ☐PA ☐Other

Radiograph(s) will be: ☐Mailed ☐Carried by patient ☐emailed to **admin@periotouch.com**

Comments:

Referred by Dr._____ Phone No._____

Please mail this form to: **12777 Valley View Street, Suite 282 Garden Grove, CA 92845** in self-stamped envelope. Thank you.