Sunshine Periodontics and Implant Dentistry

Dr. Simha Kukunooru

Patient Name_____

Phone: _____ Email: _____

Referring Doctor: _____

Office Phone & Email: _____

Exam Type: ( ) Comprehensive Evaluation ( ) Limited Evaluation ( ) Antibiotic Prophylaxis Indicated

Reason for Referral (check all that apply):

- ❑ Periodontal Pockets / Inflammation
- ❑ Crown Lengthening / Gingivectomy
- ❑ Gingival Recession/No attached tissue/Frenectomy
- ❑ Peri-implant mucositis / Peri-implantitis
- ❑ Biopsy
- ❑ Other: _____
- ❑ Extraction(s) / Root amputation
- ❑ Placement of Dental Implants
- ❑ Ridge Augmentation
- ❑ Sinus elevation and graft
- ❑ Removal of failing dental implant
- ❑ All-on-X (Maxillary / Mandibular / Both)

( ) UR quadrant ( ) LR quadrant ( )UL quadrant ( ) LL quadrant ( ) All four quadrants

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

Please email referral and any supporting records (most recent radiographs, Clinical photographs, medical clearances etc.) to **consult@sunshineperio.com**

Additional Notes:

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Office Phone: 727-222-3220
Email: consult@sunshineperio.com
Website: www.sunshineperio.com
Address: 1799 66th Street North, St. Petersburg, FL