Patient's Name

Appointment Date _____ Time: _____

Referring Dr.

WESTERN RESERVE PERIODONTICS, INC.

Practice Limited to Periodontics
with Services in Dental Implants

☐ Parkway Medical NORTH Bldg.
3609 Park East Dr., Suite 411
Beachwood, Ohio 44122-4309
216-464-8985

☐ 34501 Aurora Rd., Suite 208
Solon, Ohio 44139
440-248-1623

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WESTERN RESERVE PERIODONTICS, INC.

Practice Limited to Periodontics with Services in Dental Implants

Charlene B. Krejci, D.D.S., M.S.D.

Sasha B. Ross, D.M.D., M.S.

Reason for referral:

☐ Generalized periodontal problems.

☐ Localized periodontal problem. Area: _____

☐ Mucogingival problem(s). Area(s): _____

☐ Crown lengthening necessary. Area (s): _____

☐ Implants. Area (s): _____

☐ Temporomandibular joint problem (TMJ).

☐ Other: _____

Remarks: _____