

*Brian S. Gurinsky, DDS, MS*  
Diplomate, American Board of Periodontology  
[www.briangurinsky.com](http://www.briangurinsky.com)

1141 18<sup>th</sup> St  
Denver, CO 80202  
Tel: 303 296-8527  
Fax: 303 296-6133

THIS IS TO INTRODUCE \_\_\_\_\_ DATE: \_\_\_\_\_

PHONE #: Hm. \_\_\_\_\_ Wk: \_\_\_\_\_

WHO IS BEING REFERRED TO YOUR OFFICE FOR:

- COMPREHENSIVE EXAMINATION
- LIMITED EXAM OF FOLLOWING AREAS: \_\_\_\_\_
- OTHER: \_\_\_\_\_

FOR THE FOLLOWING CONDITION:

- GENERALIZED PERIODONTAL DISEASE
- LOCALIZED PERIODONTAL PROBLEM: \_\_\_\_\_
- MUCOGINGIVAL DEFECT: \_\_\_\_\_
- IMPLANT CONSULTATION: \_\_\_\_\_
- CROWN LENGTHENING (FUNCTIONAL/AESTHETIC)
- ACUTE PERIODONTAL ABSCESS
- OTHER: \_\_\_\_\_

I AM SENDING THE FOLLOWING:  BY MAIL  WITH PATIENT

- FULL MOUTH SERIES
- BITE WING RADIOGRAPHS
- PERIAPICAL RADIOGRAPHS
- PANORAMIC RADIOGRAPH
- PLEASE TAKE: \_\_\_\_\_
- MEDICAL CONSULTATION NEEDED

SPECIFIC RESTORATIVE PLANS: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

FROM DR.: \_\_\_\_\_ OFFICE#: \_\_\_\_\_

EMAIL: \_\_\_\_\_ DATE: \_\_\_\_\_