

FAX REFERRAL FORM

Referring Doctor: _____ Date: _____

Patient: _____

Phone: _____

Any significant Medical History? _____

Any necessary pre-medication? _____

REASON FOR REFERRAL:

Evaluation and Consultation Periodontitis
 Emergency Crown Lengthening
 Recession Implant
 Other _____

PREVIOUS PERIODONTAL THERAPY in your office and date:

None Maintenance Only Scaling / Root planning - Date: _____
 Periodontal Sx Implants Regeneration

RECOMMENDED TREATMENT PLAN MAY INCLUDE:

(Please indicate the general dentistry you have recommended to your patient)

Operative #: _____ Crown #: _____ Fixed Bridge #: _____
 Veneers #: _____ Endodontics #: _____ Extractions #: _____
 Partial or Full Dentures: _____ Implants #: _____ Other: _____
 Comments: _____

Radiographs: FMX BWX Pano
 Take X-rays Return X-rays after appointment

Referring Dentist: _____

NOTICE OF CONFIDENTIALITY

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