Prestige Periodontal and Dental Implant Surgery PLLC

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REFERRAL FORM

Date: _____ **Referring Doctor:** _____

Patient's Name: _____ Date Of Birth: _____
Telephone Number: _____
Medical Concerns: _____
_____

Dental Insurance: _____

SCHEDULING: **[ ]** PATIENT WILL CALL **[ ]** PLEASE CALL PATIENT

Periodontal Referral:

Complete Exam with special attention to _____
Limited Exam (List teeth numbers) _____

Crown Lengthening: _____ Pocket Reduction: _____
Gingival Recession: _____ Ridge Augmentation: _____
Extraction(s): _____ Ortho Exposure: _____
Site Preservation/Bone Graft: _____ Dental Implant(s): _____
Tori/Exostosis Reduction: _____ Frenectomy: _____
Third Molars: _____ Sinus Augmentation: _____
Biopsy (Area) : _____

Has Scaling and Root Planing been completed? ____ Yes Date(s) completed: _____
____ No

Radiographs:
___ Panoramic ___ FMX ___ Bitewings/Periapicals Date Taken: _____

Patient will bring ____
Image will be emailed ____
Image will be mailed ____

Do you have any restorative plans for your patient?
_____

Implant referral:
Please list your desired Implant position(s): _____

What is your preferred Implant System?: _____