

Thank you for allowing us to be a part of your dental team. We take your trust in us very seriously. Please let me know how we can help your patient achieve the oral health they desire.

Date: _____

Referring Dentist: _____

Patient Name: _____

Home phone: _____ Work Phone: _____

Cell Phone: _____ Email address: _____

Primary Concern/ Reason for Referral:

<u>Emergency Evaluation:</u>	<u>Increased pocket depth:</u>
<u>Mucogingival Defects:</u>	<u>Dental Implant:</u>
<u>Esthetic Surgical Procedure:</u>	<u>Evaluation of Dental Implant:</u>
<u>Crown Lengthening</u>	
<u>Ridge Augmentation:</u>	<u>Oral Lesion</u>
<u>Interdisciplinary Treatment Plan:</u>	

Has the patient been seen for non-surgical periodontal treatment? Please note dates:

Will you be forwarding diagnostic information? Please specify below:

<u>Full mouth series</u> Date:	<u>Panoramic Image</u> Date:
<u>BWX</u> Date:	<u>3D CBCT</u> Date:
<u>Periapicals</u> Date:	<u>Photos</u>