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Referring Doctor: ______________________________________Phone: ________________Date:___________

Introducing Patient: ____________________________________Phone: _______________________________

Pertinent Medical History:____________________(ie: Antibiotic Pre-Med): ______________________________

APPOINTMENT:

- ❑ Made For Patient: Date: ___________________ Time:_____________________
- ❑ Patient instructed to call for an appointment:_______________________________
- ❑ Please contact patient for appointment: Contact phone: ______________________

NATURE OF REFERRAL:

- ❑ Periodontal Disease *(Comprehensive Exam - FMX required)*
- ❑ Biopsy
- ❑ Dental Implants
- ❑ LANAP *(Laser Assisted New Attachment Procedure - FMX required)*
- ❑ Other ____________________________________
- ❑ CT Scan
- ❑ Isolated Area (Teeth #s _______________) *(Limited Exam-PA required)*
- ❑ Recession/Mucogingival Defects
- ❑ Crown Lengthening
- ❑ Implant site preparation/ridge augmentation

AREA OF CHIEF CONCERN:

			A	B	C	D	E	F	G	H	I	J			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
			T	S	R	Q	P	O	N	M	L	K			

RADIOGRAPHS:

- ❑ Were: mailed (date) _________________ emailed (date)_________________
- ❑ Sent with patient
- ❑ Please take

For the most thorough diagnosis and treatment a recent FMX is requested.

Remarks or Special Instructions:

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Tentative Restorative Treatment Plan: ____

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