Laser Implant Periodontal
SPECIALIST

REFERRAL FORM

Date: _____

Referring Dentist: _____
Hygienist: _____

Patient Name:_____
Patient DOB: _____
Patient Address: _____
City, Postal Code: _____
Home Phone: _____
Cell Phone: _____
e:_____

Patient Referred For:
[ ] crown lengthening_____
[ ] oral path/biopsy _____
[ ] extraction/ridge preservation_____
[ ] sinus lift _____
[ ] pocketing_____
[ ] recession/MGD_____
[ ] gummy smile _____
[ ] implant/s _____
[ ] bone loss [ ] mobility [ ] drifting
[ ] ridge augmentation
[ ] IV sedation needed for treatment?
[ ] Laser Treatment discussed
[ ] perio/prosthetic treatment planning
[ ] endo/perio _____

Dental Insurance Information:

1) Plan #1
Group or Policy #_____
Certificate or ID # _____
Company Name: _____
Name Policy Holder: _____
Birthdate: _____
Name Employer: _____
Position with Employer: _____

2) Plan #2
Group or Policy #: _____
Certificate or ID# _____
Company Name: _____
Name of Policy Holder: _____
Birthdate: _____
Name of Employer _____
Position with Employer _____

Details (site, implant system etc): _____
_____
_____
_____
_____

Pertinent History (ie allergies, smoking)
_____

Anticipated Restorative Plan
_____

Recent Images Enclosed: Yes [ ] Accompany patient [ ] emailed [ ] N/A [ ]

Communication:
[ ] paper/fax _____
[ ] phone _____
[ ] email/text _____

[ ] urgent
[ ] call me regarding this patient
[ ] before appt [ ] after appt
[ ] no need, written correspondence OK

Comments:

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