Referral Information

Patient's Name: _____________________________
Referring Doctor's Name: _____________________________
Referring Doctor's Phone: _____________________________
Referring Doctor's Email: _____________________________
Date: _____________________________

Reason for Referral

Comprehensive Periodontal Care
Periodontal Regeneration
Treatment of Gingival Recession
Esthetic Tissue Contouring
Treatment of Excessive Gingival Display (Gummy Smile)
Crown Lengthening
Implant: site ____________
Peri-Implant Disease Therapy
Alveolar Ridge Augmentation
Sinus Augmentation
Extraction
Ridge Preservation Socket Grafting
All-On-4 Implant Therapy
Vestibuloplasty
Surgically Facilitated Orthodontic Therapy (SFOT)
Mucosal Pathology
Osseous Pathology

History of Periodontal and Implant Therapy

Prophylaxis
Scaling and root planing Date: ____________
Periodontal Surgery Site: ____________ Date: ____________
Tooth Extraction Site: ____________ Date: ____________
Bone Graft Site: ____________ Date: ____________
Dental Implant Site: ____________ Date: ____________

Comments