CARY PERIODONTICS AND IMPLANT DENTISTRY

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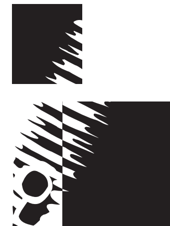

New Patient Fax Referral Form

Introducing: ______________________________ Home #: ______________ Work #: ____________

Patient referred by: ______________________________________ Date: _______________________

Patient referred for:

- ❑ Full periodontal evaluation __________________
- ❑ Isolated periodontitis: _____________________
- ❑ Assess tooth prognosis: ____________________
- ❑ Crown lengthening: ________________________
- ❑ Gingival recession: ________________________
- ❑ Frenulectomy: _____________________________
- ❑ Surgical exposure and bracket: _______________
- ❑ Esthetic crown lengthening: _______________
- ❑ Dental implant(s): _______________________
- ❑ Implant site prep: _______________________
- ❑ Intravenous sedation: ____________________
- ❑ Other: _________________________________

Restorative or prosthetic plan: ❑ Established ❑ Discussed with patient ❑ Pending perio. findings

Comments regarding restorative or prosthetic planning: _____________________________________

Radiographs available: (please indicate dates of) ❑ FMX___________ ❑ BWs __________ ❑ PAs____________ ❑ Panorex________ ❑ Other____________________________

Special patient needs or instructions: ____

The confidence that you expressed in permitting us to participate in your patient's dental care is greatly appreciated. Thank you!