CARY PERIODONTICS & IMPLANT DENTISTRY

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Patient Referral Form

Introducing: _____ Cell Phone #: _____ Email: _____

Patient referred by: _____ Date: _____

Reason(s) for Referral:

- ☐ Full periodontal evaluation_____
- ☐ Isolated Periodontitis_____
- ☐ Gingival Recession_____
- ☐ Crown Lengthening_____
- ☐ Esthetic Gingival Contouring_____
- ☐ Expose and Bond_____
- ☐ Extraction/Ridge Preservation_____
- ☐ Dental Implant(s)_____
- ☐ Sinus Lift_____
- ☐ Ridge Augmentation_____
- ☐ Sedation_____
- ☐ Other_____

Comments:_____

_____

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Radiographs available:

(please indicate dates) FMX_____ PA(s)_____ Pan_____ CBCT_____

We appreciate and value your kind referrals!