



# CARY PERIODONTICS & IMPLANT DENTISTRY

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## Patient Referral Form

Introducing: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Patient referred by: \_\_\_\_\_ Date: \_\_\_\_\_

### Reason(s) for Referral:

- |   |  |
|---|--|
| <input type="checkbox"/> Full periodontal evaluation _____  | <input type="checkbox"/> Extraction/Ridge Preservation _____ |
| <input type="checkbox"/> Isolated Periodontitis _____       | <input type="checkbox"/> Dental Implant(s) _____             |
| <input type="checkbox"/> Gingival Recession _____           | <input type="checkbox"/> Sinus Lift _____                    |
| <input type="checkbox"/> Crown Lengthening _____            | <input type="checkbox"/> Ridge Augmentation _____            |
| <input type="checkbox"/> Esthetic Gingival Contouring _____ | <input type="checkbox"/> Sedation _____                      |
| <input type="checkbox"/> Expose and Bond _____              | <input type="checkbox"/> Other _____                         |

Comments: \_\_\_\_\_

\_\_\_\_\_

Radiographs available:

(please indicate dates) FMX \_\_\_\_\_ PA(s) \_\_\_\_\_ Pan \_\_\_\_\_ CBCT \_\_\_\_\_

**We appreciate and value your kind referrals!**