

Laser Implant Periodontal
SPECIALIST

REFERRAL FORM

Date: _____ **Referring Dentist:** _____

Patient Information:

Name: _____ DOB (M/D/Y): _____

Address: _____

City: _____ Postal Code: _____

Home Phone #: _____ Cell #: _____

Email: _____

Dental Insurance Information:

Plan #1: Group/Policy #: _____ Certificate/ID #: _____

Company Name: _____ Policy Holder Name: _____

DOB (M/D/Y): _____ Name of Employer: _____

Plan #2: Group/Policy #: _____ Certificate/ID #: _____

Company Name: _____ Policy Holder Name: _____

DOB (M/D/Y): _____ Name of Employer: _____

Reason for Referral:

Crown Lengthening Biopsy/Pathology Extraction & Implant

Periodontal Disease Recessing & Gingival Grafting Hopeless Prognosis

Recent X-rays available: Yes (mailed or emailed?) None Available

Pertinent History: (ie: allergies, health conditions, smoking)

Doctor Comments: Please contact me PRIOR to Consult Written letter after Consult OK

(Please place office stamp/label on form)