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)

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