

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)