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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