PERIODONTAL AND IMPLANT REFERRAL FORM

Patient Name:_____Phone No: _____
Referring Doctor Name: _____ Phone No: _____
Address: _____

Patient Referral To:

- Dr. Alan Pomeranz
- Dr. Emilio Arguello
- Dr. Marc Reissner
- Dr. Neil Neugeboren
- Dr. Marcuschamer

Reason for Referral

- Comprehensive Periodontal Evaluation
- Bone Graft / regeneration
- Implant Evaluation
- Osseous Surgery
- Crown Lengthening
- Gingivectomy
- Soft Tissue Grafts
- Frenectomy
- Emergency Evaluation (problem focused)
- Other

Tooth #(s) _____ Quads: _____

Has the patient had previous periodontal therapy?

- None
- Prophylaxis Only
- Antimicrobial Therapy
- Scaling and Root Planning
- Surgery

Have you advised the patient of the possibility of extraction of any teeth? Yes No
If yes which teeth?

_____
_____

Does the patient require premedication? Yes No

Antibiotic used: _____

Radiographs:

_____
Please take/send copy Patient will bring copy I will send / Please return

Your Restorative Plans

Comments:

_____
_____

Please

Call me before seeing the patient
Alternate recare appointments
Send me report

Call me after seeing the patient
Do all recare
Call patient to schedule

General Dentist signature: **Date:**