Dental Implant/Periodontal Referral Fax Sheet

Fax: 210.826.6733

Date: ______________________________ Referring Doctor: ____________________

Patient Name: ______________________________ D.O.B.: ____________________

Address: ______________________________ City/State/Zip: ____________________

Telephone Numbers: Home: ________________ Work: ________________ Cell: ____________

Reason for Referral: _____Implants _____Perio _____Tissue Grafting _____Crown lengthening

Implant/s numbers/areas: ______________________________

Periodontitis: ______ Full-mouth ______ Limited areas: ______________________________

Recession areas/teeth numbers: ______________________________

Crown lengthening areas/teeth numbers: ______________________________

Other: ______________________________

Radiographs being sent:

_____ FMX _____ BWXR _____PA _____ PANO Date taken: ______________________________

_____ Please take necessary radiographs.

Stents or models being sent? _____Yes _____ No

Date of most recent periodontal charting: ____________________ Is this being sent? ____Yes ____No

Appointment status:

____An appointment was made by our office. Date: ________________ Time: ________________

_____ Please call patient.

_____ Patient will call for an appointment.

Notes: