IMPLANTWIDE

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Popular Services Provided

- Δ Comprehensive periodontics
- Δ Dental implants
- Δ All on 4, 6, X
- Δ Laser gum treatment
- Δ Zirconia implants

# REFERRAL FORM

From: Dr. _____ Date _____

Patient Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Requires Premedication: ☐ Yes ☐ No Drug Allergies: _____

## Reason for Referral:

___ Comprehensive Periodontal Evaluation _____
___ Localized Periodontal Evaluation # _____
___ Gingival Recession/Root Coverage # _____
___ Call Doctor before/after examining patient

___ Contact patient after _____ days
___ Implant Consultation # _____
___ Crown Lengthening # _____
___ Emergency _____
___ Other _____

## Radiographs: (please circle the appropriate)

___ Take FMX/send copy to me
___ I am mailing FMX/pano/individual periapicals

___ Patient bringing FMX/pano/individial periapicals
___ Please duplicate & return my X-rays
___ FMX / PAN - taken on _____

Comments: _____

Restorative Treatment Plans include: _____

*This message is intended for the use of the individual or entry to which it is addressed, and may contain information that is privileged, confidential and exempted from disclosure under applicable law. If the reader of this message is not intended recipient you are hereby notified that any dissemination, distribution or copying of the communication is strictly prohibited. If you received this in error please notify us via phone or fax.*

*We look forward to working together to serve our mutual patients.*

*Dr. G & Dr. B*

ONLINE FORM

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