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PATIENT REFERRAL

We look forward to welcoming you to our practice. If you have any questions prior to your visit, please contact us.

Patient

Name ____

Email ___________________________________

Phone __________________ ☐ Mobile ☐ Home ☐ Work

Doctor

Name ____

Email ___________________________________

Phone __________________ ☐ Office ☐ Mobile

Referral

Diagnostics

- ☐ Comprehensive periodontal exam
- ☐ Limited exam
- ☐ Biopsy
- ☐ Microbial testing
- ☐ Multi-disciplinary treatment planning
- ☐ CBCT

Implants

- ☐ Implant placement
- ☐ Implant site development
- ☐ Ridge augmentation
- ☐ Sinus augmentation
- ☐ Digital workflow planning
- ☐

Periodontics I Disease control

- ☐ Initial therapy I Home care & habits
- ☐ Dental clearance for surgery
- ☐ Tooth extraction I Ridge preservation
- ☐ Periodontal surgery
- ☐ Laser surgery
- ☐ Peri-implantitis I Peri-mucositis
- ☐ Functional crown lengthening

Perioplastic surgery

- ☐ Gingival grafting
- ☐ Esthetic crown lengthening
- ☐ Esthetic tissue contouring
- ☐ Frenectomy
- ☐ Other

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