

PATIENT REFERRAL FORM

Diplomate of the American Board of Periodontology

PRACTICE LIMITED TO PERIODONTICS WITH SERVICES IN DENTAL IMPLANTS,
ORAL MEDICINE, AND LASER SURGERY

Please take a moment and complete this form, indicating where we may be of
service and assistance to both you and your patient.

Patient: _____

Referring Doctor: _____

Concord Lexington

Phone: _____

How may we assist your patient and you in the treatment of your patient?

Please examine treatment plan completely and comprehensively

- Bone loss and/or periodontal pocketing and/or furcation involvement _____
- Gingival recession and/or mucogingival problems _____
- Crown lengthening may be necessary (teeth # _____)
- Guided tissue regeneration may be necessary _____
- Consultation for dental implants (teeth # _____)
- Observed gingival inflammation _____
- Observed oral pathology _____
- Extraction (teeth# _____) Reason _____

Models (Diagnostic casts)

- Available Unavailable
- Send by mail _____ Brought by patient _____
- Please call our office
- FMX will be supplied via mail/email (CIRCLE ONE)
- FMX unavailable — please take
- FMX will be brought to consultation by patient
- Patients has been in my practice for _____ years Or patient is new _____

Prosthetic/restorative plans, comments, concerns, case description

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