PATIENT REFERRAL

CENTERS FOR SPECIALIZED DENTISTRY

Periodontics, Implants, Comprehensive & Integrative Dentistry

John V. Louis, DMD

INTRODUCING: _____

APPOINTMENT DATE AND TIME: _____

PHONE: _____

PLEASE BRING THIS FORM TO YOUR APPOINTMENT.

DATE _____ REFERRING DR. _____ OFFICE ❑ EASTON ❑ SALISBURY

This patient is being referred for evaluation of the following:

❑ Biopsy
- ❑ Biopsy Area _____

❑ Exposure Tooth # _____

❑ Extraction Tooth # _____
- ❑ Socket Preservation

❑ Frenectomy
- ❑ Tongue
- ❑ Lip
- ❑ Other _____

❑ Dental Implants Tooth # _____
- ❑ Nobel Biocare
- ❑ Zimmer/Biomet
- ❑ Implant Bridge
- ❑ Implant Retained Overdenture
- ❑ Hybrid

❑ Alveoloplasty Tooth # _____

❑ Bone Grafting

❑ Periodontal Evaluation of _____

❑ Periodontal Prosthetic Evaluation of _____
- ❑ Entire Dentition
- ❑ Tooth # _____

❑ Gingival Grafting Tooth # _____

❑ Clinical Crown Lengthening Tooth # _____

❑ Ridge/Sinus Augmentation Areas _____

❑ Evaluate Maxillary/Mandibular Arch for TIAD

❑ Sleep Apnea

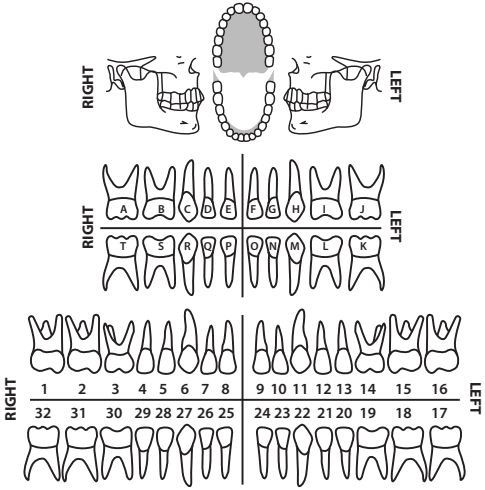
❑ TMJ Evaluation

❑ Other _____

Diagnostic

❑ CBCT Scan for Implant Placement

❑ CBCT Scan for Diagnostic Evaluation



In order to assist in the diagnosis, I have enclosed the following radiographs:

❑ Complete Series ❑ Bitewings

❑ Panorex ❑ Single Films ❑ CBCT

I have sent them via:

❑ Mail ❑ E-Mail

❑ Patient will bring

Follow Up Request:

❑ Please call the office to consult about patient care at the initial examination visit.

❑ Please send a written report of findings and plan of continuing care.