Periodontal Referral

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_____ , 20____
Date of Referral

Introducing my patient: _____

DOB (m/d/y): _____ Tel: Res._____ Bus._____

Address:_____

City:_____ Postal Code:_____

Insurance? ❑ Yes ❑ No

Policy Holder's Name _____DOB (m/d/y): _____

1st Plan:_____ Gr # _____ID/Cert _____

Policy Holder's Name _____ _____DOB (m/d/y): _____

2nd Plan: _____ Gr # _____ID/Cert _____

REFERRED FOR:

❑ Comprehensive examination and treatment

❑ Specific examination/Treatment of areas: _____

_____

❑ Crown lengthening	❑ Soft tissue graft	❑ Surgical exposure
❑ Implants	❑ Regeneration	❑ Extraction
❑ Biopsy	❑ Frenectomy	❑ Fiberotomy

❑ Other: _____

Special Considerations: _____

_____

_____

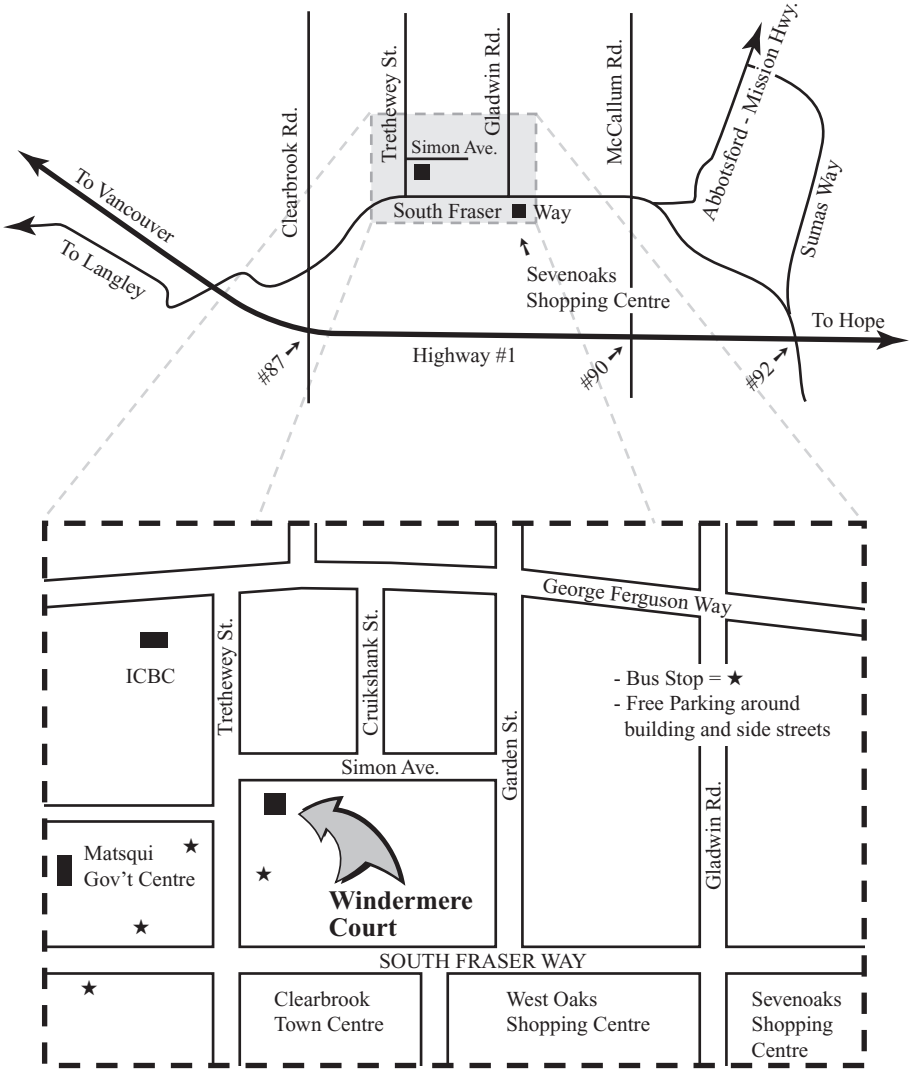
Radiographs: ❑ Enclosed (Return/Keep) ❑ Emailed ❑ Take

drhenrylouie@telus.net

Referring Doctor: _____ Tel: _____

Address: _____

Copies: White→mail/fax to our office Yellow→to patient Pink→dentist record



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Appointment: Date: _____

Time: _____