

Periodontal Treatment Referral

Please complete this form and fax it to 909.469.8650. Please contact The Dental Center for an appointment at 909.706.3910.
We must have this form BEFORE we can schedule an appointment. The cost of the initial appointment \$46.00-\$ 57.00.

PATIENT INFORMATION

Patient's Name *(Please print)* _____
Patient Date of Birth _____
Patient Primary Telephone/Mobile Number _____
Other Telephone/Mobile Number _____

REFERRING DOCTOR

Doctor's Name *(Please print)* _____
Practice Name _____
Address _____
City _____ State _____ Zip _____
Telephone _____ Fax _____
Email _____

RADIOGRAPHS AND CLINICAL PHOTOGRAPHS

New radiographs may need to be taken at appointment.
Radiographs sent with patient Clinical photos sent with patient

RELEVANT CLINICAL INFORMATION

Please Indicate Specific Tooth Number(s)/Area(s): _____

Please Indicate Procedure(s) you are referring for evaluation: Select all that apply

- Pocket Reduction Surgery Soft Tissue Graft Bone Graft/Guide Tissue Regeneration Periodontal Consult
- Other (Please Specify Below): _____

DOCTOR SIGNATURE, DATE AND FAX REQUIRED

Dr. _____
Date: _____
Fax: _____