coastal empire periodontics
& implant dentistry

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PATIENT: _____ PATIENT DOB: _____ PATIENT PHONE #: _____

APPOINTMENT DATE: _____ TIME: _____

Insurance Provider: _____ Policy ID: _____ Insurance Phone #: _____

REFERRING BY DR. _____ PHONE: _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

REASON FOR REFERRAL:

- ☐ Complete Periodontal Evaluation (FMX Required)
- ☐ Gingival Contouring for Cosmetics
- ☐ Graft for Root Coverage
- ☐ Ridge Augmentation / Pontic Site Development
- ☐ Extraction #'s _____
- ☐ Crown Lengthening
- ☐ Orthodontic Exposure
- ☐ Third Molar Extractions
- ☐ Other: _____
- ☐ Implant #'s _____
  - ☐ Anticipate Bone Graft and/or Sinus Lift

Please bring referral card to appointment.

RADIOGRAPHS (Please email as single images in a JPEG format):

- ☐ Are being sent: ____FMX ____ PA ____ BW ____PANO ____ CT Scan
- ☐ Need to be taken

Periodontal Treatment Completed in your Office:

- ☐ New Patient
- ☐ Oral hygiene instruction & maintenance q ___ months since: _____
- ☐ Scaling and root planning ____UR ____UL ____LL ____LR: Date: _____

Have you advised the patient of the possibility of extraction of any teeth? If yes, which tooth numbers?

_____

Is there any other dentistry that needs to be completed and/or comments?

Please allow 48 hours to reschedule appointments.