coastal periodontics
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Diplomate of the American Board of Periodontology

FAX REFERRAL FORM

Referring Doctor: _____ Date: _____
Patient: _____
Phone: _____

Any significant Medical History? _____

_____

Any necessary pre-medication? _____

REASON FOR REFERRAL:

_____ Evaluation and Consultation
_____ Emergency
_____ Recession
_____ Other _____
_____ Periodontitis
_____ Crown Lengthening
_____ Implant

PREVIOUS PERIODONTAL THERAPY in your office and date:

_____ None
_____ Periodontal Sx
_____ Maintenance Only
_____ Implants
_____ Scaling / Root planning - Date: _____
_____ Regeneration

RECOMMENDED TREATMENT PLAN MAY INCLUDE:
(Please indicate the general dentistry you have recommended to your patient)

Operative #: _____
Veneers #: _____
Partial or Full Dentures: _____
Crown #: _____
Endodontics #: _____
Implants #: _____
Fixed Bridge #: _____
Extractions #: _____
Other: _____
Comments: _____

_____

Radiographs: _____ FMX _____ BWX _____ Pano
_____ Take X-rays
_____ Return X-rays after appointment

Referring Dentist: _____

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