Periodontal Specialties

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Periodontics | Dental Implants

PATIENT _____ **DATE** _____

REASON FOR REFERRAL:

☐ PERIODONTAL EVALUATION
☐ IMPLANT CONSULTATION
☐ TMD
☐ EMERGENCY PROBLEM
☐ DIAGNOSIS OF ORAL LESION
☐ OTHER - PLEASE SPECIFY

REMARKS: _____

_____

HAS PATIENT HAD PERIODONTAL TREATMENT WITHIN PAST 24 MONTHS?

☐ NO ☐ YES ☐ SRP ☐ SURGERY

DATE OF LAST: FMX _____ BITEWINGS _____

RADIOGRAPHS:

☐ NO X-RAYS ☐ BEING MAILED ☐ BEING EMAILED
☐ PATIENT BRINGING ☐ PLEASE CALL AFTER PATIENT EVALUATION

(See Back for HIPAA Secure Email)

REFERRING DR. _____

PHONE: _____ **EMAIL:** _____

NOTE TO PATIENTS:

Your first visit with us is typically an exam and consultation. We will review your clinical and x-ray findings and develop a treatment plan.

- Please bring this referral slip with you.
- Other patient forms are available on our website and can be filled out at your convenience.
- Please bring a complete list of your prescription and over the counter medications.
- If you require antibiotic premedication before dental procedures, please take that 1 hour before your appointment.
- Payment is expected at the time of service.
- All major credit cards are accepted.

Please visit our website

www.periodontalspecialtiesmi.com

STERLING HEIGHTS

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CLINTON TOWNSHIP

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Clinton Township, MI 48038
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NEW BALTIMORE

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