

Periodontal Specialties

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Periodontics | Dental Implants

PATIENT _____ DATE _____

REASON FOR REFERRAL:

- | | |
|---|---|
| <input type="checkbox"/> PERIODONTAL EVALUATION | <input type="checkbox"/> EMERGENCY PROBLEM |
| <input type="checkbox"/> IMPLANT CONSULTATION | <input type="checkbox"/> DIAGNOSIS OF ORAL LESION |
| <input type="checkbox"/> TMD | <input type="checkbox"/> 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. _____

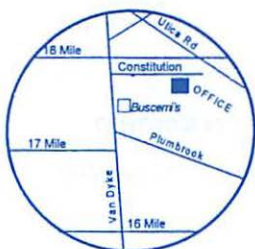
PHONE: _____ EMAIL: _____

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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