BAY IMPLANT, PERIO, & ENDO

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Referring Doctor: _____ Date: _____

Best way to reach referring doctor: _____

Patient Name: _____

Address: _____

Phone No.: _____

How long has Patient been in your Practice? _____

What is the reason for the referral? _____

_____

What do you want to accomplish with restorative treatment regarding this referral?

_____

Has any treatment been accomplished to correct problem? Y / N.

If so please describe:_____

_____

_____ IMPLANT REFERRAL: Preferred treatment plan:

_____

☐ Immediate Placement

☐ Provisional Restoration if Possible

☐ Not sure what is best, let's talk

☐ PERIODONTAL REFERRAL

☐ Crown Lengthening #_____

☐ Esthetic CL/gingivectomy Area:

_____

☐ IV Sedation

☐ Localized bone loss # _____

☐ Gingival grafting # _____

☐ Exposure of clinical crowns # _____
Attach Brackets Y / N

☐ Frenectomy Area: _____

☐ Wisdom Teeth Removal

☐ Sinus Augmentation (Bone Grafting)