

## **Metro East Dental Implants & Periodontics**

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## **Referral Sheet - No Cover Sheet Required If Faxed**

From:	Date:	
Patient Name:		
Home Phone:	Cell Phone:	
Require Pre-medication?    Yes    No  Reason for Pre-Med:  REASON FOR REFERRAL		
☐Comprehensive Periodontal Evaluation	☐Implant Consultation; Site(s) #	
☐Aesthetic Crown Enhancement #	☐Functional Crown Lengthening #	
☐Gingival Recession /Coverage #	☐Bone Grafting:	
□Cuspid Exposure: #	☐Emergency:	
RADIOGRAPHS		
Most recent radiographs taken:	Date:	
☐Radiographs are being mailed	☐Patient is bringing Radiographs	
☐Radiographs are being emailed	☐Please take Radiographs	
Comments:		
Restorative Plan:		

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