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: _____