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Specialist Referral Form

Referring Provider Information

Referring Dentist: _____ Date: _____

Dental Office: _____

Submitted By (Staff Member): _____

Phone: _____

Email: _____

Patient Information

Patient Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Address: _____

_____

Appointment Status

- ☐ AppointmentScheduled
- ☐ Patient Will Call
- ☐ Please Contact Patient

Appointment Date: _____

Appointment Time: _____

Reason for Referral (Check all that apply)

- ☐ Peridontal Disease Consultation
- ☐ Dental Implant Consultation
- ☐ Ridge Augmentation
- ☐ Extraction
- ☐ Exposure of Impacted Tooth
- ☐ L-PRF with Bonegraph
- ☐ All on X/4
- ☐ Orthodontic Extraction
- ☐ Full Mouth Implant (Overdenture, All-on-4, Full Fixed...)
- ☐ Crown Lengthening
- ☐ Frenectomy
- ☐ Gigivectomy
- ☐ IV Sedation Dentistry
- ☐ Botox for TMJ
- ☐ Neurotoxin Treatment
- ☐ Other: _____

Clinical Notes:

_____

_____

_____

Please send your recommended treatment plan and/or any performed procedures (if applicable) which may pertain to my consultation: ☐ Treatment Plan ☐ Radiographs ☐ Diagnostic Models

Call Referring doctor before treatment: ☐ Yes ☐ No

Any Impressions taken? _____

Any temporary prosthesis planned? _____

Last recall/hygiene date & procedure? _____

Next Dental Appointment? _____

Please email or fax the documents prior to the patient appointment. Feel free to call or email us with questions.

Referring Doctor Signature

Signature: _____

Date: _____