WILMINGTON
PERIODONTICS &
IMPLANT CENTER

Patient Referral Information:

Introducing:_____ DOB:_____

Address: _____

Phone Number(s): Home:_____ Cell:_____ Work:_____

Email Address:_____

Referring Office/Doctor:_____

Referral Reason (Check all that apply):

☐ Periodontal Evaluation: _____

☐ Dental Implants (#'s):_____

☐ Recession/Mucogingival Defects (#'s):_____

☐ Crown Lengthening (#'s):_____

☐ Expose & Bond (#'s):_____

☐ Extractions (#'s):_____

Medical Alerts / Concerns:_____

Does the patient require antibiotic pre-medication? ☐ Yes ☐ No

Diagnostic Information:

☐ Wilmington Periodontics & Implant Center to take Radiographs (Preferred)

☐ Related Radiographs being sent: ☐ Electronically ☐ Patient ☐ Other

Appointment Status:

☐ Referring Doctor has scheduled the appointment while the patient is in the office.

☐ The appointment is scheduled for (Date/Time):_____

☐ Please call the patient and coordinate an appointment.

☐ Patient will call to schedule an appointment.

Location:

☐ **Wilmington Office**

1611 Doctors Circle

Wilmington, NC 28401

☐ **Southport Office**

4330 Southport Supply Road

Southport, NC 28461

Please email this form to: info@wilmingtonimplantcenter.com

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