



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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