



**Patient Referral Information**

Introducing: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email Address: \_\_\_\_\_

Referring Doctor/Office: \_\_\_\_\_

**Referred for (check all that apply):**

- Periodontal Evaluation \_\_\_\_\_
- Dental Implant #(s) \_\_\_\_\_
- Recession or Mucogingival Evaluation #(s) \_\_\_\_\_
- Crown Lengthening #(s) \_\_\_\_\_
- Other/Comments \_\_\_\_\_

**Medical Alerts:** \_\_\_\_\_

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

**Diagnostic Information:**

- Wilmington Periodontics & Implant Center to take radiographs (preferred)
- Related radiographs being sent via: (circle one) mail / electronically / patient / other
- Date of image(s) \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

**Appointment Status:**

- Referring doctor will schedule appointment while patient is in the office (preferred)
- Please call patient and coordinate an appointment
- Patient will call to schedule an appointment
- Appointment is scheduled for (day/date/time) \_\_\_\_\_

**Location:**

**Wilmington**  
1611 Doctors Circle  
Wilmington, NC 28401

**Southport**  
4330 Southport-Supply Road #206  
Southport, NC 28461

**Please email or fax to our office: [accounts@wilmingtonimplantcenter.com](mailto:accounts@wilmingtonimplantcenter.com) | Fax: 910.772.1553**

(Phone, email and fax are the same for both locations)

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