



Periodontics

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REFERRAL INFORMATION

PLEASE NOTE: ALL requested information in this form must be completed to avoid any delays in booking consultation appointment.

- This is a consultation appointment only. **Duration-Approximately 2 Hours**
- Cancellation notice of **3 business days** is required for any appointment to avoid a **cancellation charge of \$250.00.**
- **Patient is responsible for providing an interpreter on the day of the appointment.**

Date: _____

1. SOURCE OF REFERRAL

Referring DDS MD: _____

Last Name

First Name

Address: _____ City _____ PC: _____

Phone #: _____ Fax #: _____ Email: _____

2. PATIENT INFORMATION: New Patient Previous Patient Patient's

Name: _____ **Gender** _____

Last Name

First Name

DOB: ____/____/____ Medical Concern: _____

dd mm yy

Address: _____ City _____ PC: _____

Home Phone #: _____ CP: _____ e-mail: _____

3. INSURANCE TYPE: (Please check all appropriate)

No Insurance Insurance Exp. Date: _____

Insurance Company _____

4. REASON FOR REFERRAL: (Check all that applies)

General Periodontal Evaluation Pre-Orthodontic Evaluation Mucogingival Surgery Root Coverage Gingival Augmentation Ridge Augmentation Treatment of Gummy Smile Crown Lengthening Pocket Reduction Surgery Enhanced Maintenance Therapy Treatment of Peri-implantitis

OTHER:

Dentist Main Concern. please specify in detail.

5. Please be as detailed as possible. This allows us to establish a history and idea of how to proceed with treatment.

How was the patient’s previous experience/cooperation within your office?

Have you completed any procedures on this patient? No Yes **(Please specify treatment rendered and date)**

Recall/NPE (last Date): _____

Radiographs (most recent)

- Yes Date Taken: _____ e-mailed or mailed send with patient
- No

Please email all appropriate radiographs with patient’s name and date taken in the subject line to sandhugumsrus@gmail.com

“Office use only”

Consult

Duration: approximately 2Hrs

Payment Policy:

Payment Due Day of Visit Visa/Mc/Debit/Cash \$_____ + x-rays (if needed)

Cancelation Policy:

3 Business Days’ Notice Requires (if Less-rebooking fee of \$250.00)

Explained/Booked with: _____

Appt Date: _____

Booked By: _____
