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(813) 872-8300
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REFERRAL FORM

Introducing: _____ Date: _____

Patient's Phone: Work: _____ Home: _____

❑ appointment scheduled ❑ contact patient ❑ patient will contact office

Please evaluate for:

❑ pocketing
❑ bone loss
❑ gingival recession / mucogingival defect
❑ gingival bleeding / hyperplasia
❑ tooth mobility / drifting
❑ crown lengthening
❑ gummy smile / short teeth
❑ frenectomy / fiberotomy
❑ ridge augmentation
❑ oral pathology / biopsy
❑ pinhole surgery
❑ other _____

Location of area of concern: _____

Do you have specific restorative plans? ❑ yes ❑ no

Initial periodontal therapy recently completed? ❑ yes ❑ no

Referred by Dr._____ ❑ Please call at _____

Comments _____

_____

Please contact me: ❑ prior to exam ❑ after exam ❑ after consult