New Orleans Periodontics
& Implant Dentistry
Dr. Hillary Wright

PATIENT REFERRAL FORM

Patient's Name ______________________ Date: __________

Patient's Phone Number: ______________________________

Reason for Referral:

( ) Complete Periodontal Evaluation
( ) Emergency Treatment
( ) Crown Lengthening
( ) Gingival or Root Coverage Graft
( ) Frenectomy
( ) Other ________________

( ) Implant Evaluation
( ) Esthetic Ridge Augmentation
( ) Expose Impacted Tooth for Orthodontics
( ) Extraction ridge preservation
( ) Biopsy

Current Available Radiographs:

( ) Bitewings ( ) Full Mouth Series ( ) Panoramic ( ) None

Treatment Rendered:

( ) Prophylaxis
( ) Root Planing

Quadrants: (Please include dates)
( ) Upper Left __________ ( ) Upper Right __________
( ) Lower Left __________ ( ) Lower Right __________

Restorative / Prosthetic Plans:

( ) Crowns
( ) Fixed Bridges
( ) Upper Cast/Treatment Partial
( ) Lower Cast/Treatment Partial

Comments:

Referring Doctor: ______________________________

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