Alice Wu, DDS, MS *Periodontics & Implants*

Southeastern Dental Specialists

SMITH & ASSOCIATES

Patient Details

Name _____ D.O.B. ____/____/____

Address _____

Cell Phone _____ Home Phone _____

Email _____

Appointment Date _____ Appointment Time _____

Referring Practitioner Details

Practice Name _____

Doctor Name _____

Office Manager _____

Address _____ Email _____

Phone _____ Referring Dr. Cell _____

General reason(s) for referral? (Localized problem, please indicate tooth or area.)

- ☐ Abscess
- ☐ ANUG
- ☐ Furcation Involvement
- ☐ Hyperplastic Tissue
- ☐ Perio-Endo Lesion
- ☐ Vertical Defect
- ☐ Crown Lengthening
- ☐ Implant Evaluation
- ☐ Ridge Augmentation
- ☐ Root Coverage Procedure
- ☐ Soft Tissue Graft
- ☐ Sinus Lift

Radiograph Status

- ☐ FMX
- ☐ Panorex
- ☐ Bitewings
- ☐ CT Scan
- ☐ Patient will bring
- ☐ We will email / mail
- ☐ Please take your own

Implant Evaluation

Location _____

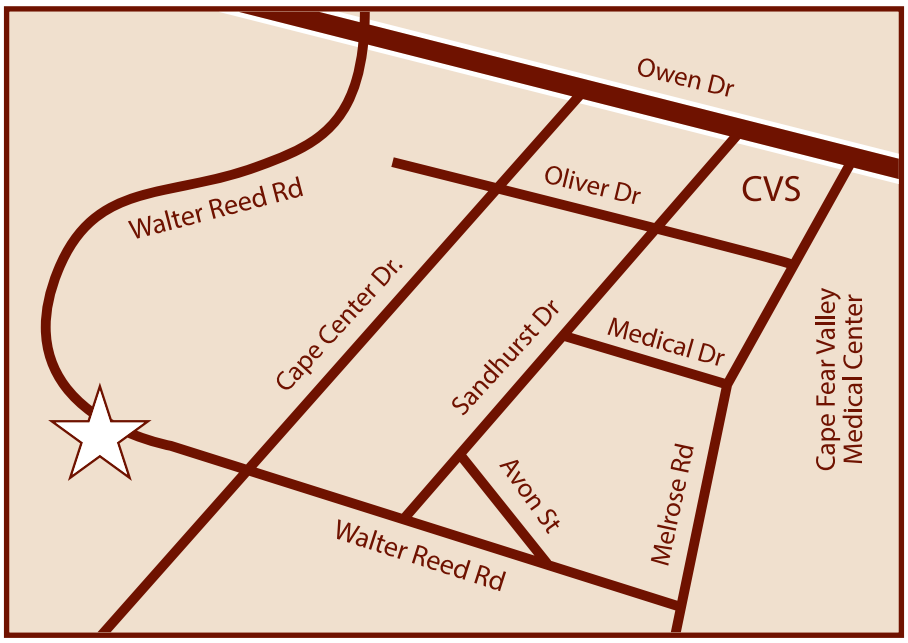
_____

Comments _____

_____

_____

Referring Doctor Signature _____ Date ____/____/____



Southeastern Dental Specialists

PERIODONTICS

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