Southeastern Dental Specialists
SMITH & ASSOCIATES

Patient Referral Form

Patient:

Name: _____ Date of birth: _____/_____/_____

Address: _____

Preferred phone: _____ Email: _____

Referring Doctor:

Name: _____ Practice Name: _____

Address: _____

Preferred phone: _____ Email: _____

Primary contact person: _____ Phone: _____

How would you like us to contact you: ___Phone ___Email ___Regular mail

Type of Referral:

____Treat and refer back ____Treatment Planning Assistance ____Treat and maintain

Enclosed materials: ____Radiographs ____Study models ____Other consultative reports

Type radiographs: ____PAX ____Pano ____CT scan ____Other

Entry A (Left side of building)

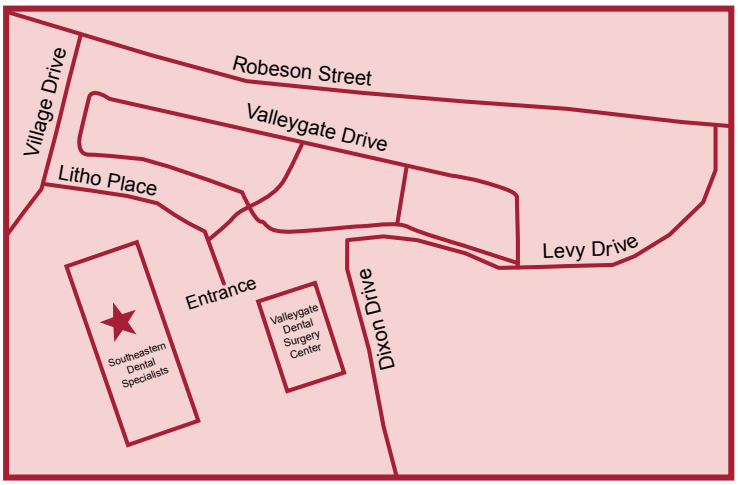
Oral Surgery
Anthony Maiorana, DDS
Bhushan Thakkar, BDS, MDS

Entry B (Right side of building)

Periodontics
Elizabeth Campbell, DDS, MS
Gabriella Ambrose, DDS

Endodontics
Achara O'Brien, DDS

Prosthodontics
Terrance Smith, DDS
Nathan Abramson, DDS



Southeastern Dental Specialists
2028 Litho Place, Fayetteville, NC 28304
Phone (910) 689-1475

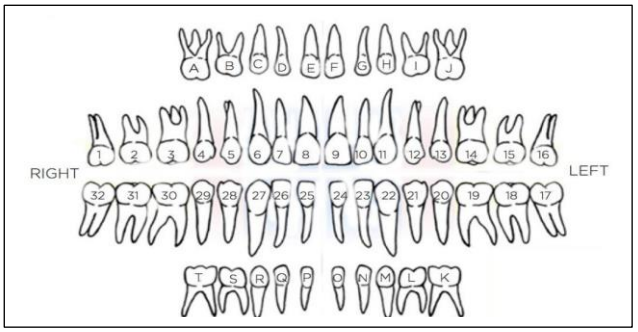
Referral To:

Endodontics: Dr. Achara O'Brien

Reason for referral: ____Consultation ____Root Canal ____Apical Surgery ____Retreatment
Tooth (teeth) number: _____ Provide post space? ____Yes ____No
Other Instructions: _____
_____

Oral and Maxillofacial Surgery: ____Dr. Anthony Maiorana ____Dr. Jeffery Aycock

Type referral: ____Consultation ____Extraction ____Pathology/Biopsy ____Implant placement
____Other



Use tooth chart to indicate teeth (tooth)
for consultation/extraction

Additional information/comments:
_____
_____

Periodontics: ____Dr. Elizabeth Campbell ____ Dr. Gabriella Ambrose

Referring for: ___ Comprehensive evaluation ___Limited exam/ specify area(s)_____
___ Crown lengthening ___ Recession ___ Implant ___ Extraction
___ Limited laser ___ LANAP ___ Canine Exposure ___ Biopsy
___ Root resorption ___ Peri-implantitis ___ Gingivectomy ___ Root amputation
___ Tori/exostosis removal

Additional info/comments**:** _____
_____

Prosthodontics: ___Dr. Nathan Abramson ___Dr. Terrance Smith

Referring for: ____ Comprehensive evaluation ____Edentulism
____ TMD/Orofacial pain ____Dental implants
____ Occlusal evaluation/tooth wear ____Obstructive sleep apnea/snoring
____ Assist with treatment planning ____Caries

Please: ____Treat and refer back ____Treat and maintain

Other referral information:
Medical History: _____
_____
Dental History: _____
_____
Treatment Plan: _____
Additional comments: _____
Doctor's signature: _____ Date: _____