



# Carolina Center for Dental Implants and Periodontics

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## Patient Referral Information

Introducing \_\_\_\_\_ DOB \_\_\_\_\_

Referring Dr. \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_

Phone number(s) home \_\_\_\_\_ cell \_\_\_\_\_

### Referred for (check all that apply):

- Periodontal Evaluation \_\_\_\_\_
- Dental Implant Tooth #(s) \_\_\_\_\_
- Extraction Tooth #(s) \_\_\_\_\_
- Recession or Mucogingival Evaluation #(s) \_\_\_\_\_
- Crown Lengthening #(s) \_\_\_\_\_
- TMJ
- Triage/Emergency \_\_\_\_\_

**Medical Alerts:** \_\_\_\_\_

- Does patient require antibiotic pre-medication?  Yes  No

### Diagnostic Information:

- Date of last radiographs \_\_\_\_\_

## APPOINTMENTS

Please scan and send all referrals to [referral@carolinaimplantcenter.com](mailto:referral@carolinaimplantcenter.com)

As soon as we receive the referral, our office will contact the patient to schedule a complimentary consultation.

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