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

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