



Carolina Center for Dental Implants and Periodontics

Patrick M. McDonough, DDS, MS, PA

2808 Village Way
New Bern, NC 28562
Office (252) 633-1631
Fax (252) 633-3922

referral@carolinaimplantcenter.com
www.carolinaimplantcenter.com

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.

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