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Westmont Smiles Dental

Patient	Referring Doctor
Patient Name: _____	Doctor Name: _____
Patient Phone: _____	Phone: _____
Patient DOB: ____/____/____	Office Email: _____

Please check reason(s) for referral:

- ☐ Comprehensive periodontal evaluation
- ☐ Limited periodontal treatment _____
- ☐ Crown lengthening (Tooth/teeth:___)
- ☐ Recession/soft tissue grafting (Tooth/area:___)
- ☐ Implant placement (Tooth # __)
- ☐ Implant maintenance procedure (Tooth # ___)
- ☐ Frenectomy
- ☐ Biopsy

Date of previous treatment:

- ☐ Prophylaxis ____/____/____
- ☐ SRP ____/____/____
- ☐ Periodontal Maintenance ____/____/____

Radiographs:

- Please indicate:
  - ☐ FMX Date taken: ___/___/____
  - ☐ BWX Date taken: ___/___/____
  - ☐ PAs Date taken: ___/___/____ Tooth No. (s)_____
- Radiographs will be:
  - ☐ Sent with patient
  - ☐ Emailed to info@westmontsmilesdental.com
  - ☐ Mailed to office

Additional information: _____

_____

Doctor Signature: _____ Date: _____