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Patient _____ Date _____

Patient's Phone No. _____ Appt. Date _____

Referring Dr. _____ Time _____

☐ Sending Radiographs/FMX ☐ Radiographs Needed

PURPOSE OF REFERRAL: ☐ Comprehensive Exam ☐ Limited Exam

Specific area of concern: _____

_____

_____

_____

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_____

☐ Periodontal Disease/Bone Loss ☐ Crown Lengthening

☐ Biopsy ☐ Extraction

☐ Gingival Recession ☐ Ridge Augmentation

☐ Tooth Exposure ☐ Dental Implants

☐ Other _____

- We appreciate your confidence -