SMILESCIENCE

MULTI-SPECIALTY DENTAL CENTER

Referring Dentist: _____

Patient Name: _____

Date of Birth (D/M/Y): _____

Home: _____ Cell: _____

Email: _____

Information / Referral Reason: (i.e. patient's chief complaint, infections, hygiene frequency)

_____

_____

_____

Please circle at least one:

Generalized Perio Perio Specific Site Frenectomy

Gingival Grafting/Recession Biopsy Laser Treatments

Crown Lengthening Implants Canine Exposure

Bone Graft/Sinus Lift Perimplantitis Other: _____

Relevant History / Information: (i.e. medical considerations, previous dental history) _____

_____

Available Radiographs (circle): FMX PAN CBCT PA BW

Date: _____

Please send all referrals to
refertosmilescience@gmail.com
or call (506) 452-7605

PERIODONTICS

SMILESCIENCE

MULTI-SPECIALTY DENTAL CENTER

Referring Dentist: _____

Patient Name: _____

Date of Birth (D/M/Y): _____

Home: _____ Cell: _____

Email: _____

Information / Referral Reason: (i.e. patient's chief complaint, current dental status, prosthetic difficulties)

_____

_____

_____

_____

Please circle at least one:

Implant Crown/Bridge Full Mouth Rehabilitation

TMD Sleep Apnea Care Esthetics Other: _____

Relevant History / Information: (i.e. medical considerations, previous dental history) _____

_____

Available Radiographs (circle): FMX PAN CBCT PA BW

Date: _____

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or call (506) 452-7605

PROSTHODONTICS