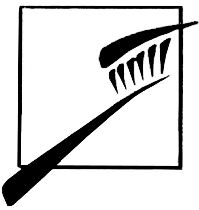

Aymee C. Spindler, D.D.S. LLC
Steven J. Spindler, D.D.S. LLC
Practice Limited to Periodontics

2540 Servern Ave., Suite 402
Metairie, LA 70002
Tel: 504-887-8205 FAX: 504-887-1115
Email: drspindler@att.net
http://www.spindlerperio.com

Patient FAX Referral Form

No cover sheet required. Simply FAX form to 504-887-1115. We will contact your patient.

Patient Section

Patient Name: ____. I authorize my doctor's office to release my confidential medical information to Dr's. Aymee and Steven Spindler. I understand that this information will be used only for my personal health care and will be protected under HIPAA Privacy Laws. I also agree to have Dr. Spindler's office contact me for an appointment.

Patient Signature: _______________________________. Telephone #s:________________________

Doctors Section

Patient is being referred to your office for:

___ generalized periodontal problem
___ localized periodontal problem ___________
___ mucogingival problem ____
___ other ____
___ oral pathology
___ biopsy _____________

Radiographs:

___ will be mailed to you
___ accompany the patient
___ are unavailable or not applicable
___ please return our originals
___ retain for your records

Restorative treatment:

___ planned: ____
___ completed: ____
___ depends upon periodontal prognosis: ____________________

Periodontal treatment to date:

___ none ___ scaling ___ root planing
___ surgery ___ maintenance (every ___ months)
___ other ____
____
____
____
____

From Dr. ________________________________
Date of referral: ___________________________

Your appointment is scheduled on:
date: _________ time: __________