FAIRFIELD PERIODONTICS

PERIODONTICS & DENTAL IMPLANTS

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PERIODONTAL REFERRAL FORM

Date ____________________________

Patient: ____ ❑ Please Call Patient

Home Phone: ____________________________________ ❑ Patient Will Call

Business Phone: ________________________________

REASON FOR REFERRAL

❑ General Periodontal Evaluation

❑ Localized Periodontal Evaluation ______________________________

❑ Crown Lengthening Surgery ______________________________

❑ Dental Implant ______________________________

❑ Consultation or Diagnosis for ______________________________

❑ Other ______________________________

Radiographs Available? ❑ No ❑ Yes PA'S BW FMX Pan Date______________

Restorative Plans:

Special Comments:

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Referring Dentist - (Please PRINT Name)

71 BEACH ROAD • FAIRFIELD, CT 06824
PHONE (203) 255-7771 • FAX (203) 255-5753

32 CHERRY STREET • MILFORD, CT 06460
PHONE (203) 878-8596 • FAX (203) 878-3662