Shelby
PERIODONTICS
ADVANCED PERIODONTAL & IMPLANT SURGERY

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Johnson City, TN 37601
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PATIENT INFORMATION:

Today's Date ____________________

First Name ______________________ Last Name ______________________ Date of Birth ____________________

Contact Telephone (   ) ______________________ Contact E-Mail Address ______________________

Does the patient require antibiotics prior to dental treatment? ❏ Yes ❏ No

REFERRING DOCTOR'S INFORMATION:

Referred By ______________________ Telephone (   ) ______________________

E-Mail Address ______________________

Referring To Dr. ______________________ At Office ______________________

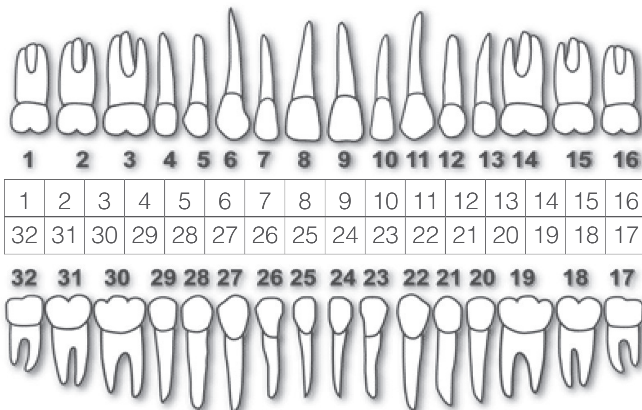
PROCEDURES:

- ❏ Extraction
- ❏ Alveoplasty
- ❏ Biopsy
- ❏ Incision & Drainage
- ❏ Intraoral Lesion
- ❏ Exposure
- ❏ Hard Tissue
- ❏ Infection
- ❏ Expose & Bond
- ❏ Soft Tissue
- ❏ Frenectomy
- ❏ Apicoectomy
- ❏ Periodontal Treatment
- ❏ Implants
- ❏ Laser Surgery
- ❏ Pre–Prosthetic
- ❏ Gingival Grafting
- ❏ IV Sedation
- ❏ Ridge Augmentation
- ❏ Oral / Facial Lesion
- ❏ Bone Grafting
- ❏ Crown Lengthening
- ❏ Other ______________________

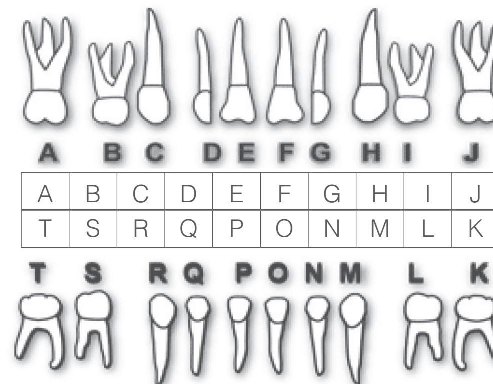
Please Verify Teeth For Extraction ______________________

Implants ______________________

Location / Notes ______________________



1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17



A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

RADIOGRAPHS OR CLINICAL PHOTOS:

- ❏ Being Mailed
- ❏ Being E–Mailed
- ❏ Given To Patient
- ❏ Please Take
- ❏ No X–Ray
- ❏ Attached – If X-Rays are attached, what date were they taken ____________________

TO ATTACH X-RAY(S) TO THIS REFERRAL FORM PLEASE SUBMIT THE FORM ABOVE OR BELOW.
DEX graphic files cannot be used by our office. Please do not submit this file type!
AFTER THE FORM IS SUBMITTED YOU WILL THEN HAVE THE OPTION TO UPLOAD X-RAYS THAT WILL BE ATTACHED TO THIS REFERRAL FORM.

COMMENTS: