Shelby
PERIODONTICS
ADVANCED PERIODONTAL & IMPLANT SURGERY

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Diplomate of the American
Board of Periodontology

American Academy of Periodontology

Appt. Date _____ Time _____

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 _____

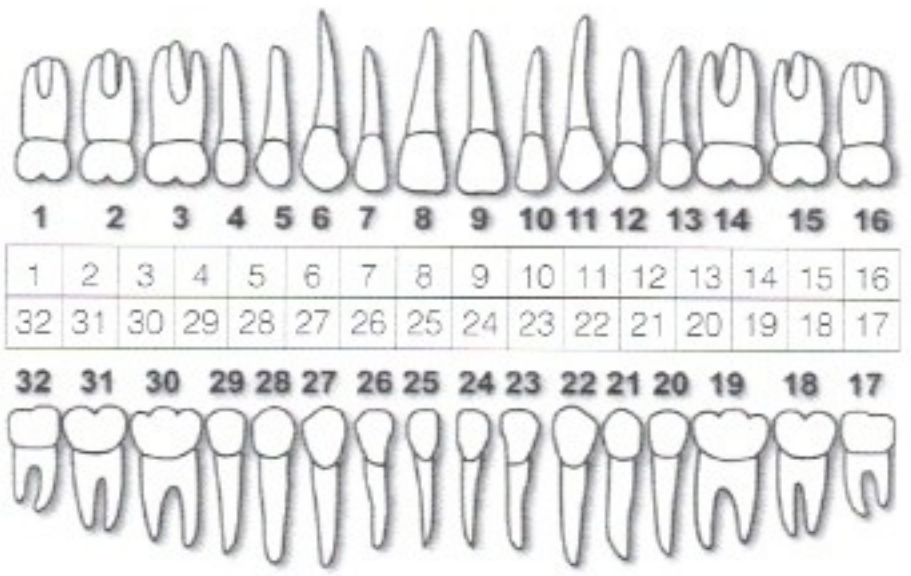
PROCEDURES:

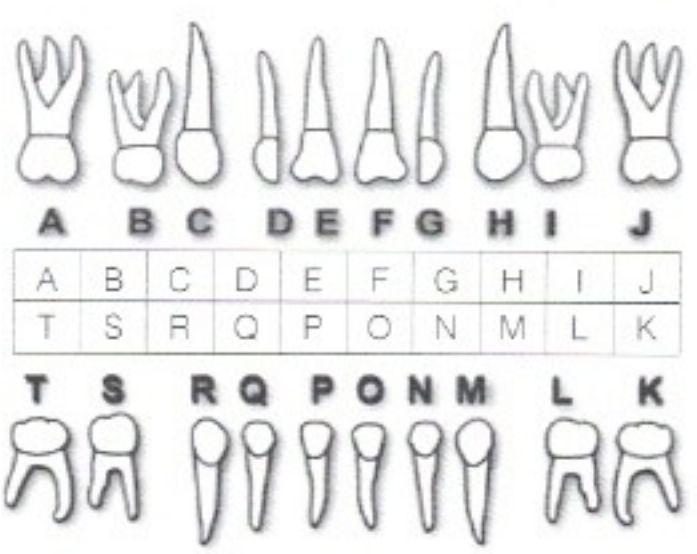
- ❑ Extraction
- ❑ Alveoplasty
- ❑ Biopsy
- ❑ Incision & Drainage
- ❑ Intraoral Lesion
- ❑ Exposure
- ❑ Hard Tissue
- ❑ Infection
- ❑ Expose & Bond
- ❑ Soft Tissue
- ❑ Frenectomy
- ❑ Apicoectomy
- ❑ Periodontal Treatment
- ❑ Implants
- ❑ Laser Surgery
- ❑ Pre-Prosthetic
- ❑ Gingival Grafting
- ❑ IV Sedation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

Please Verify Teeth For Extraction _____

Implants _____

Location / Notes _____





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: