HIGH BRIDGE PERIODONTICS

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Periodontal and Implant Specialist

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Introducing Patient: _____ D.O.B. _____
Address: _____ City: _____ Zip: _____
Phone: _____ Email: _____

Referred by Dr: _____ Date of referral: _____

Office Email: _____ Office Phone: _____

☐ Please contact patient
☐ Patient to call

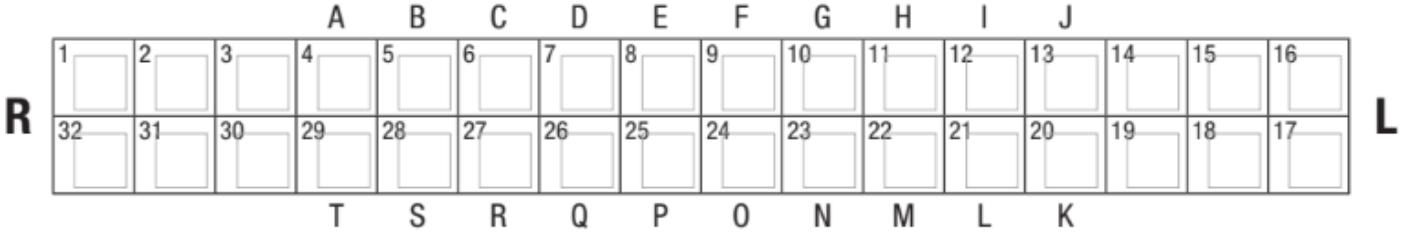
Is antibiotic prophylaxis needed? ☐ Yes ☐ No
Is the patient on blood thinners? ☐ Yes ☐ No
Is the patient on medication for osteoporosis? ☐ Yes ☐ No

History of periodontal treatment? ☐ No ☐ Yes - date(s) of treatment: _____

Consultation:
☐ Tooth extraction/Bone grafting
☐ Dental implants
☐ Gingival/Soft tissue grafting
☐ Periodontitis
☐ Other (crown lengthening, biopsy, etc.) :_____

Radiographs:
We request all current radiographs be sent with referral.
☐ No radiographs ☐ Please take ☐ Accompanying patient
☐ Radiographs attached:
☐ FMX ☐ Panoramic ☐ Bitewings ☐ Periapical(s)

Indicate Location:



Additional Comments:

Please email this form to Frontdesk@highbridgeperiodontics.com. Thank you!