

Scott A. Smith, D.D.S.

PERIODONTICS & DENTAL IMPLANTS

Exceptional care for a lifetime of healthy, beautiful smiles

REFERRAL FORM

LOCATION

1156 Olivewood Dr Merced, CA 95348

1065 Colorado Ave. Ste 2 Turlock, CA 95380

PATIENT INFORMATION

* First Name:

* Last Name:

* Phone:

Email:

Appointment Date:

Appointment Time:

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

If Yes: _____

I AM REFERRING THIS PATIENT FOR

Dental Implants-Placement Evaluation

Crown Lengthening

Periodontal-Evaluation & Treatment

Bone Regeneration / Ridge Augmentation

Periodontal Limited Evaluation & Treatment

Recession/Tissue Grafting

Periodontal-Cosmetic Evaluation

Emergency/Abcess

Frenectomy

































Extraction/Ridge Preservation

Biopsy

Cold Sore Treatment

Other: _____

PLEASE CHECK THE TEETH TO BE EVALUATED

															
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

PERIODONTAL TREATMENT PERFORMED BY REFERRING OFFICE ALREADY

Scalling & Root Planing UR UL LL LR ALL Periodontal Maintenance

RADIOGRAPHS

To diagnose and treatment plan patients thoroughly, a full mouth (FMX) set of radiographs are required.

Being Mailed/Emailed to the Practice Accompanying Patient No x-rays available, please take & forward
a copy to our office

CASE PLANNING

Please contact referring doctor before examination
 Please contact referring doctor after examination to discuss treatment options
 No contact necessary, please send periodontal examination report
I Preferred to be contacted by: Phone Fax Secure Email Regular Mail

PATIENT CONTACT

Patient will call for appointment Please call patient for appointment

REFERRING DOCTOR INFORMATION

* Referred By: * Phone:

* Email:

COMMENTS OR RESTORATIVE TREATMENT PLAN:

All Fields Marked with '*' must be completed.

1156 Olivewood Dr.
Merced, CA 95348
209-205-4657



1065 Colorado Ave. Ste 2
Turlock, CA 95380
209-417-1099