

PATIENT REFERRAL

Patient Name: _____ Patient Date of Birth: _____

Referred By: _____ Referral Date: _____

Comments: _____

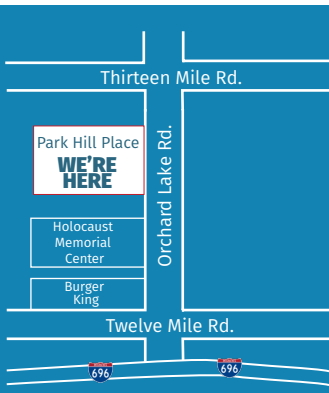
x-rays emailed x-rays given to patient

- | | | |
|---|--|--|
| <input type="checkbox"/> Extractions | <input type="checkbox"/> TMJ Evaluation | <input type="checkbox"/> Exposure |
| <input type="checkbox"/> Implant Surgery | <input type="checkbox"/> Preprosthetic Surgery | <input type="checkbox"/> Expose and Bond |
| <input type="checkbox"/> Bone Graft/Site Preservation | <input type="checkbox"/> IV Sedation | <input type="checkbox"/> Frenectomy |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> 3D Imaging | <input type="checkbox"/> Alveoloplasty |
| <input type="checkbox"/> Lesion and Tumor Management | <input type="checkbox"/> Infection | <input type="checkbox"/> Other |

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

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

Please note that, in most cases, the patient is seen for consultation first to review the health history, decide on the most appropriate anesthesia and treatment plan, then schedule the surgery appointment.



**Please bring this referral slip
to your appointment.**

WE LOOK FORWARD TO MEETING YOU !

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