UMPQUA PERIODONTICS & DENTAL IMPLANTS

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Patient
Name/DOB ______________________________ Date ___/_____/________

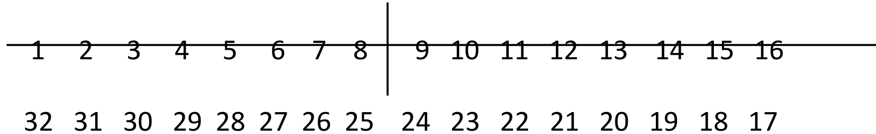
Address ______________________________ Phone # ________________

Appointment Scheduled For:

Day ______________ Date ___/___/____ Time ___:____ am/pm

Reason for Referral:

- ○ Periodontal Consult/Treatment (Full mouth)
- ○ Specific Problem Areas Only ______________________________
- ○ Dental Implants
- ○ Gingival Grafting
- ○ Crown Lengthening
- ○ Extraction - Bone Graft/Socket Preservation



Comments: ____

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- ○ Sending current radiographs _____ FMX _____ PAS
- ○ Premedication required

Referring Doctor ______________________________________

Thank you for your referral.