Miller Bounds
PERIODONTICS
DENTAL IMPLANTS

Please fill out the form below and click submit to e-mail, you can also print the form and fax it to (949) 857-4611

Referral Form

NAME _____ AGE _____

HOME TELEPHONE _____ HOME TELEPHONE _____

REFERRING DOCTOR _____ DATE _____

CONSULTATION
- ☐ Complete Periodontal Examination
  - ☐ Periodontal Treatment Recommendations
  - ☐ Restorative/Prosthetic Recommendations
- ☐ Limited Periodontal Examination
  - ☐ Recession/Mucongingival Problems
  - ☐ Crown Lengthening
  - ☐ Emergency/Abscess
  - ☐ Other
- ☐ Implant Consultation

PREVIOUS PERIO Tx IN REFERRING DOCTOR'S OFFICE
- ☐ None
- ☐ Routine Prophylaxis ☐ Regularly every _____ months ☐ Irregulary
- ☐ Quadrant Scaling and Root Planing ☐ With Anesthesia ☐ Without Anesthesia
  Date: _____
- ☐ Other: _____

DIAGNOSTIC
Type: ☐ FMX ☐ Panorex ☐ Bitewings ☐ PA's
Date: _____ _____ _____ _____
Please sent available radiographs with this referral. Thank you.

APPOINTMENT INFO.
- ☐ Patient has an appointment on _____
- ☐ Patient will call your office for an appointment
- ☐ Please call the patient to arrange for an appointment

OTHER INFO. _____

_____

_____

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Steven J. Bounds, D.D.S., M.S.
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