PERIODONTAL Medicine

Surgical SPECIALISTS

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Referral Fax - No Cover Sheet Required

From: Dr.		Date:		
Referring to:	Dr. Mandelaris Park Ridge Oakbrook Terrace Lincoln Park	Dr. DeGroot Park Ridge Oakbrook Terrace Lincoln Park	First Available	
Patient Name				
Home Phone	Cell Phone _		Work Phone	
Requires Premedication Yes No Reason for Pre-Med				
Esthetic Crow Gingival Rece Oral Medicine Emergency:	REFERRAL ve Periodontal Evaluation on Enhancement, Site # ssion / Root Coverage; Site # / Pathology Consult	Functional Crow Interdisciplinary Cuspid Exposu Other:	tation; Site # wn Lengthening; Site # y Consult / SFOT re	
RADIOGRAPHS	S			
Most recent radiographs taken:			Date:	
Radiographs are being mailed Radiographs are being emailed to office@periodontalmedicine.org		Please take Rac	 □ Patient is bringing Radiographs □ Please take Radiographs CBCT Scan □ Yes □ No □ Please take 	
Comments:				
Restorative Treatm	nent Plan:			

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