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Patient Name: _____

Reason for referral:

- Periodontitis
- Gingival recession #
- Extraction and/or Implant #
- Crown lengthening #
- Others:

X-rays:

- Emailed to:
- Given to patient
- No X ray taken

Prefer to be contacted by:

- Email:
- Letter address to:
- Phone:

Comments: _____

Referring Doctor /Office : _____

Referring Doctor Signature and Date: _____