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Periodontics and Implant Dentistry

PLEASE BRING THIS REFERRAL SLIP WITH YOU

Introducing ______________________________ Date: ____________

Referring Doctor ____

Appointment ______________________________________ am/pm
Day Date Time

Reason for Referral:

☐ Comprehensive Exam and Treatment ☐ Evaluation for Implants
☐ Soft Tissue Grafting/Recession ☐ Other

Specific Concerns:

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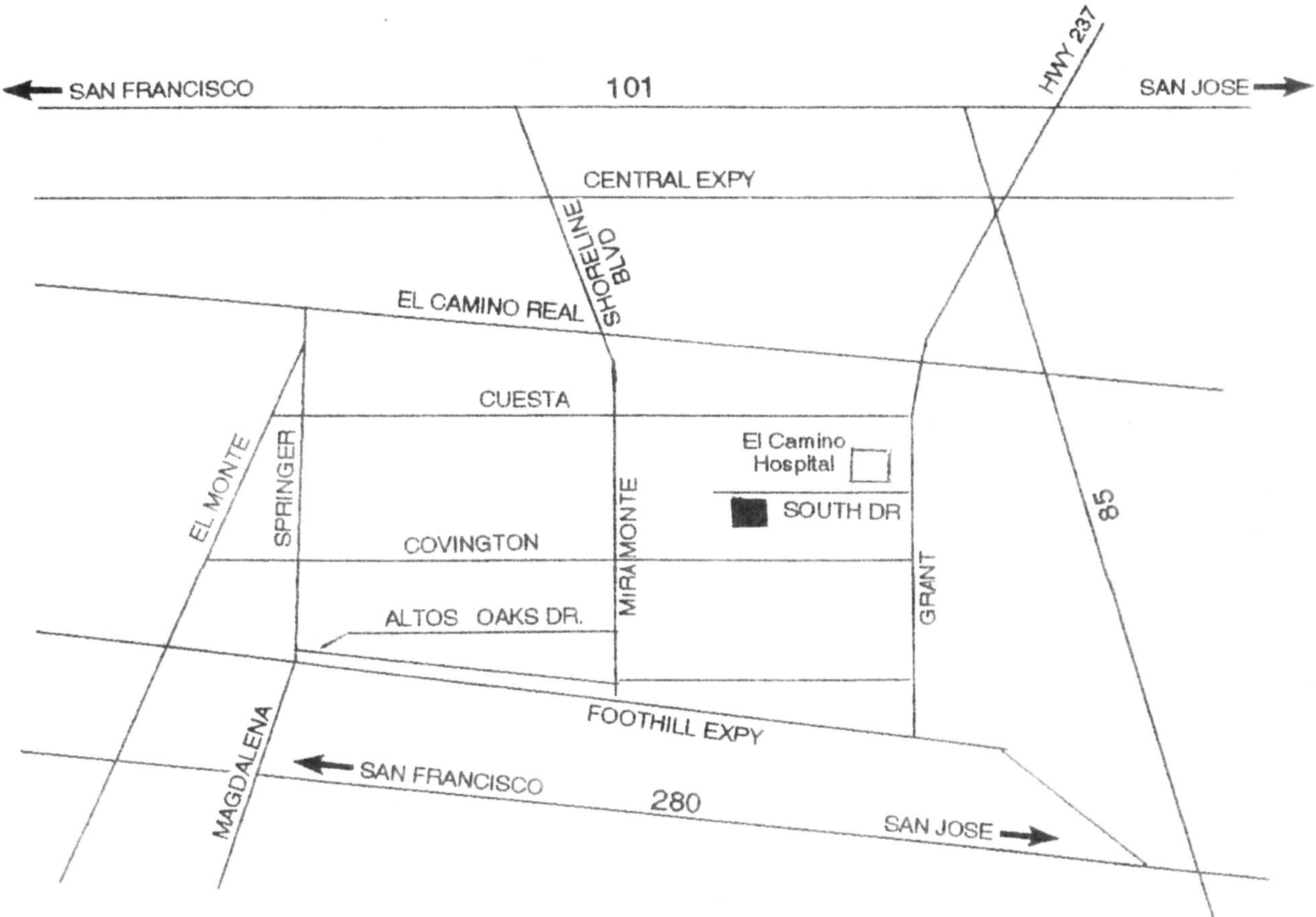
Radiographs: ☐ Please Take ☐ Attached ☐ Mailed ☐ E-mailed

WHITE - Patient's Copy YELLOW - Referring Doctor's Copy


SAN FRANCISCO
101
HWY 237
SAN JOSE
CENTRAL EXPY
SHORELINE BLVD
EL CAMINO REAL
CUESTA
El Camino Hospital
SOUTH DR
85
EL MONTE
SPRINGER
COVINGTON
MIRAMONTE
GRANT
ALTOS OAKS DR.
FOOTHILL EXPY
MAGDALENA
SAN FRANCISCO
280
SAN JOSE