SIERRA DENTAL

Date_____

Dr. Javier Cabrales
DMD, MDent Perio
Certified Specialist in Periodontology

Patient's Name_____

DOB_____Phone Number_____

Email Address_____

Medical Alerts/Allergies/Concerns_____

_____

Referring Dentist

Name_____Clinic_____

Email_____Phone_____

Radiographs: ☐ Panoramic ☐ CBCT ☐ FMX ☐ BWs ☐ PAX

Reason for Referral:

☐ Comprehensive Periodontal Exam

☐ Specific Periodontal Exam

- ☐ Restorative Crown Lengthening
- ☐ Ridge Augmentation
- ☐ Recession / Keratinized Tissue
- ☐ Esthetic Crown Lengthening
- ☐ Sinus Augmentation
- ☐ Unerupted Tooth Exposure - Please place gold chain Yes ____ No ____
- ☐ Extraction
- ☐ Other _____

☐ Implant Consultation Site(s)_____

- ☐ Bone Level_____ ☐ Tissue Level (RN / WN)

Refer internally to additional Specialist(s) if recommended: Yes No

Comments:

Thank you for the confidence of your referral.

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