



# AUBURN

PERIODONTICS & IMPLANTOLOGY

Patient \_\_\_\_\_

Phone Number \_\_\_\_\_ Date \_\_\_\_\_

Referring Doctor \_\_\_\_\_

Appointment Date \_\_\_\_\_ Time \_\_\_\_\_

**Reason For Referral:**

Complete Examination  Limited Examination

Specific Areas:  Teeth Numbers \_\_\_\_\_

UR  LR  UL  LL

Crown Lengthening: # \_\_\_\_\_

Tissue Graft: # \_\_\_\_\_

Implants: # \_\_\_\_\_

Other: \_\_\_\_\_

**Please Call:**

Before Consult  After Consult  No Call Necessary

Radiographs:  Sending with Patient  Please Take

Comments: \_\_\_\_\_



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