

TROY PERIODONTICS & DENTAL IMPLANTS

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INTRODUCING: _____ DATE REFERRED: ____/____/____

REASON FOR REFERRAL:

- | | | | |
|--|--|--|--------------------------------------|
| <input type="checkbox"/> SINUS LIFT | <input type="checkbox"/> IMPLANT PLACEMENT | <input type="checkbox"/> PERIODONTAL DISEASE | <input type="checkbox"/> EMERGENCY |
| <input type="checkbox"/> CROWN LENGTHENING | <input type="checkbox"/> EXTRACTION | <input type="checkbox"/> PERI-IMPLANT DISEASE | <input type="checkbox"/> IV SEDATION |
| <input type="checkbox"/> SOFT TISSUE GRAFT | <input type="checkbox"/> BONE GRAFT | <input type="checkbox"/> ORAL PATHOLOGY/BIOPSY | <input type="checkbox"/> CT SCAN |

- TOOTH#/SITE#/QUADRANT _____
- OTHER _____

X-RAY BEING FORWARDED SCALING AND ROOT PLANING IN THE LAST 2 YEARS? NO YES

- REFERRING DR. _____

EMAIL A LETTER MAIL A LETTER CALL THE OFFICE

PLEASE EMAIL OR FAX THE REFERRAL TO DR. KORKIS' OFFICE