deborahruprecht DDS
periodontics & implant specialty

PATIENT REFERRAL INFORMATION

Introducing

_____ Patient name

_____ Phone number

_____ Address

_____ Email

Reason for referral

_____ Comprehensive periodontal care

_____ Limited (problem-focused) care

_____ Aesthetic tissue contouring

_____ Alveolar ridge augmentation

_____ Crown lengthening

_____ Dental implant

_____ Excessive gingival display (Gummy smile)

_____ Gingival recession

_____ Oral-facial aesthetics

_____ Peri-implant disease

_____ Periodontal regeneration

_____ Ridge preservation / Socket grafting

_____ Sinus augmentation

_____ Tooth extraction

History of periodontal and implant therapy

_____ Bone graft

Site: _____ Date: _____

_____ Prophylaxis

Site: _____ Date: _____

_____ Dental implant

Site: _____ Date: _____

_____ Scaling and root planing

Site: _____ Date: _____

_____ Periodontal surgery

Site: _____ Date: _____

_____ Tooth extraction

Site: _____ Date: _____

Radiographs

Do you have recent radiographs?

_____ Yes.

Please email to the preferred location:

Ladera Ranch	**Mission Viejo**	**Solana Beach**
samrasmiles@gmail.com	cheryl@henrykimdmdpc.com	info@inspiresmilessd.com

_____ No, please take radiographs as needed.

Referring Doctor

_____ _____

Name Phone number

_____

Email

Thank you kindly for your referral.