ASTORIA
PERIODONTICS AND IMPLANTS P.C.

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Introducing:_____ Referral is the courtesy of:_____ Today's Date: ____/____/____

Patient Address: _____

Birthdate: _____/_____/_____ Gender: _____ Contact Phone: _____ ☐ Please call patient ☐ Patient will call for appointment

Teeth # or area to be treated_____

Procedure(s) Requested

- ❑ Extraction(s)
- ❑ Would you like us to discuss: implants or bone grafting? ___Yes ___ No
- ❑ Biopsy / Excision
- ❑ Other:_____
- ❑ Alveoloplasty
- ❑ Frenectomy
- ❑ Exposure / Bond
- ❑ Incision / Drainage

❑ Cone Beam CT Scan

Consultation(s) Requested

- ❑ Dental implants
- ❑ Sinus Lift
- ❑ Bone grafting
- ❑ Facial Trauma
- ❑ Other:_____
- ❑ Oral Pathology
- ❑ Soft tissue grafting
- ❑ Skin lesions

Radiograph Requests

❑ Enclosed/Emailed ❑ Given to patient ❑ Please take new ones

Management, Medical or Treatment concerns

_____

_____

Please fax, mail, or email this form to the office.

PLEASE CIRCLE TEETH / AREA TO BE TREATED