Dr. Bruce M. Crawford
Implant Dentistry & Laser Periodontics

PATIENT REFERRAL FORM

Introducing: _____ Date: _____

Phone: _____ Email: _____

	POSTERIORS							ANTERIORS							POSTERIORS	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
R																L
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

PLEASE EVALUATE FOR:

Periodonal Therapy

- Periodontal Laser Therapy (LANAP/LAPIP)
- Periodontal Disease
- Bone Loss
- Pinhole Gum Grafting /Tunneling
- Connective Tissue Grafting
- Alloderm
- Cosmetic Gum Surgery “Gummy Smile”
- Crown Lengthening
- Other _____

Implant Therapy

- Full Arch/Full Mouth Implants
- Dental Implants
- Bone Graft/Gore Tex
- Extraction/Socket Preservation
- Frenectomy/Fiberotomy
- Tooth Mobility/Drifting
- Sinus Lift
- Ridge Augmentation
- CT Scan

X-Ray(s) Taken: Pano Full Series Bite Wings Single P.A. CT Scan

X-Ray(s) Received: Emailed Sent with Patient

Periodontal Treatment to Date: Prophylaxis Root Planning/Curettage

Patient Needs to be Premedication: Yes No

Remarks/Instructions: _____

Referred By Doctor: _____

Doctor Phone: _____ Doctor Email: _____

Appointment: Date: _____ Time: _____ AM PM

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