Associated Dental

Tinisha Notice DDS, MS
Periodontist
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PERIODONTAL REFERRAL FORM

Patient Name ______________________ DOB ____________ Date ____________

Patient's Phone # ______________________ Email Address ______________________

Patient's Mailing Address ____

Referred By ____________________ Referring Office ______________________

RADIOGRAPHS

_____ Please take a FMX, a recent FMX is not available

_____ A recent FMX is available and _____ will be sent with the patient _____ will be mailed

_____ Recent periapical x-rays of the area(s) to be evaluated will be sent

REASON FOR REFERRAL

_____ Periodontics

- Consultation
- Implants/Bone Grafting
- Soft Tissue Grafting
- Limited Perio Eval
- Other ____________________
- Crown Lengthening
- Osseous Surgery
- Gingivectomy
- Comprehensive Perio Eval

INSURANCE

Name of Insurance Company ____

Phone # of Ins. Co ____

Employer of Subscriber ____

Subscriber DOB ____

Subscriber SSN ____

Pt's relationship to the subscriber ____

REFERRING OFFICE: SCAN AND EMAIL WITH RELEVANT RADIOGRAPHS TO ADCCARONDELET@MYDENTALMAIL.COM

Dear Patient - We look forward to serving you. Please call us at (520) 733- 9225 to schedule an appointment. Your first visit will be an evaluation only including review of your medical history and recent radiographs. The required x-rays will be taken if not available. Please bring a list of all medications and supplements you are currently taking. Please allow 90 minutes for your visit and arrive 10 minutes early to complete the registration paperwork. You may pre-register at www.adctucsoneastcarondelet.com. Any patient under the age of 18 must be accompanied by a parent or legal guardian.