



Associated Dental

**PERIODONTAL & IMPLANT
REFERRAL FORM**

TINISHA NOTICE, DDS, MS
3773 W Ina Rd, Ste 180 | Tucson, AZ 85741
520-579-8166
adcpina@mydentalmail.com
adctucsonwestina.com

Today's Date _____
Patient Name _____
Patient Phone/Email _____
Referring Doctor/Office _____
Office Phone/Email _____

I have referred the above patient to you for:

- Periodontal Disease: Generalized | Tooth # _____
- Laser Osseous Surgery (LANAP)
- Recession | Inadequate Soft Tissue # _____
- Implant Consultation # _____
- Extraction/Explantation and Ridge Preservation # _____
- Peri-implant Diseases and Conditions # _____
- Functional Crown Lengthening # _____
- Esthetic Crown Lengthening (gummy smile)
- Ridge Augmentation | Sinus Elevation # _____
- Frenectomy | Vestibular Advancement
- Biopsy | Oral Lesions | Mucositis # _____
- IV Sedation
- SRP | Periodontal Maintenance
- Treatment Planning | Full Mouth Rehabilitation

ADDITIONAL INFORMATION/COMMENTS _____

REFERRING OFFICE INFORMATION

Patient is scheduled for Periodontal Maintenance on (date) _____
Available Radiographs (within last year) FMX Panorex PA
Referring office to complete our own SRP Perio Maintenance Implant Placement
Patient history of SRP _____
Planned Restorative Treatment _____

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

Dear Patient - We look forward to serving you. Please call us at 520-579-8166 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 registration paperwork. You may pre-register at www.adctucsonwestina.com. Any patient under the age of 18 must be accompanied by a parent or legal guardian.