PATIENT REFERRAL

advanced
DENTAL SPECIALISTS

Date:

Appointment Date/Time:

PATIENT NAME:	PHONE:
REFERRED BY:	DDS PHONE:
PLEASE EVALUATE AND/OR TREAT THE FOLLOWING:	
RADIOGRAPHS INCLUDED? ☐ Yes ☐ No	HAS PATIENT REQUESTED SEDATION? ☐ Yes ☐ No

ENDODONTICS	PERIODONTICS	ORAL SURGERY	EMAIL REFERRAL FROM AND RADIOGRAPHS TO:
☐ Mayfair	☐ Appleton	☐ Bayshore	**Appleton:** ADSAppleton@mydentalmail.com
☐ Waukesha	☐ Franklin	☐ Franklin	**Bayshore:** ADSBayshore@mydentalmail.com
	☐ Green Bay	☐ Madison	**Franklin:** ADSFranklin@mydentalmail.com
	☐ Mayfair	☐ Mayfair	**Green Bay:** ADSGreenBay@mydentalmail.com
	☐ Racine	☐ Waukesha	**Madison:** ADSMadisonWest@mydentalmail.com
	☐ Waukesha		**Mayfair:** ADSMayfair@mydentalmail.com
			Racine: ADSRacine@mydentalmail.com
			Waukesha: ADSWaukesha@mydentalmail.com

ENDODONTICS CONSULTATION	PERIODONTICS CONSULTATION		ORAL SURGERY CONSULTATION
Tooth/Teeth #: ______________	Tooth/Teeth #: ______________		Tooth/Teeth #: ______________
☐ Apicoectomy	☐ Full mouth	☐ Local area	☐ Full mouth
☐ Root Canal	☐ Biopsy	☐ Bone graft	☐ Alveoloplasty
☐ Retreatment RCT	☐ Implant	☐ Osseous surgery	☐ Biopsy
☐ Call me about case	☐ Gingivectomy	☐ Extraction	☐ Bone graft
☐ Leave post space	☐ Crown lengthening		☐ Exposure and bond bracket
☐ Other:	☐ Occlusal considerations		☐ Extraction
	☐ Soft tissue graft		☐ Implant
	☐ Other:		☐ Local area
			☐ Other:

Comments:

Thank you for your confidence, trust, and kind referral!

RFRL5693KS