REFERRAL TO OFFICE

DR. ABBASALI HASSANALI — **PERIODONTIST**

Date: _____

Referring Doctor (s): _____

Referring Doctor Phone Number: _____

Patient Name: _____ Date Of Birth: _____

Phone Number: _____ Email: _____

Parent/Guardian Name: _____ Gender: ☐ Male ☐ Female

Insurance: ☐ Yes ☐ No

Dental Insurance Details: *Name & DOB of policy holder, Policy number & member ID number*

_____

_____

REASON FOR REFERRAL: ☐ Complete Periodontal Examination ☐ Specific Examination

☐ Gingival Recession

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

☐ Deep Pocket/Bone Loss

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

☐ Crown Lengthening

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

☐ Dental Implant (s)

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

☐ Extraction (s)

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

☐ Pathological Lesion (s)

☐ Frenectomy

Sedation Requested: ☐ Yes ☐ No

Sedation: ☐ Oral Sedation ☐ IV Sedation ☐ General Anesthesia

Radiographs: ☐ None Available ☐ Sent with Patient
☐ Emailed to *info@niagaradentalspecialists.ca*

Significant Medical History: _____

_____

_____

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