

# RANDALL R. GORDON, DDS, MS

PRACTICE LIMITED TO PERIODONTICS AND DENTAL IMPLANTS

## PATIENT REFERRAL FORM

Introducing \_\_\_\_\_ Date \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_

Referring Dentist \_\_\_\_\_

An appointment has been reserved for you on \_\_\_\_\_ Time \_\_\_\_\_

### Dental Implant Therapy

Implant Placement # \_\_\_\_\_

Extraction + Immediate Implant # \_\_\_\_\_

Sinus Lift # \_\_\_\_\_

Ridge Augmentation # \_\_\_\_\_

Implant Overdenture \_\_\_\_\_

### Periodontal Therapy

Comprehensive Periodontal Exam \_\_\_\_\_

Isolated Periodontal Needs # \_\_\_\_\_

Gingival Recession/Grafts # \_\_\_\_\_

Esthetic/Functional Crown-Lengthening # \_\_\_\_\_

Soft Tissue Biopsy/Oral Pathology \_\_\_\_\_

X-Rays: \_\_\_FMX \_\_\_PA/BW \_\_\_PANO

\_\_\_Patient will bring \_\_\_Will be mailed \_\_\_Will be e-mailed

[xrays@gordonperioimplants.com](mailto:xrays@gordonperioimplants.com)

Other/Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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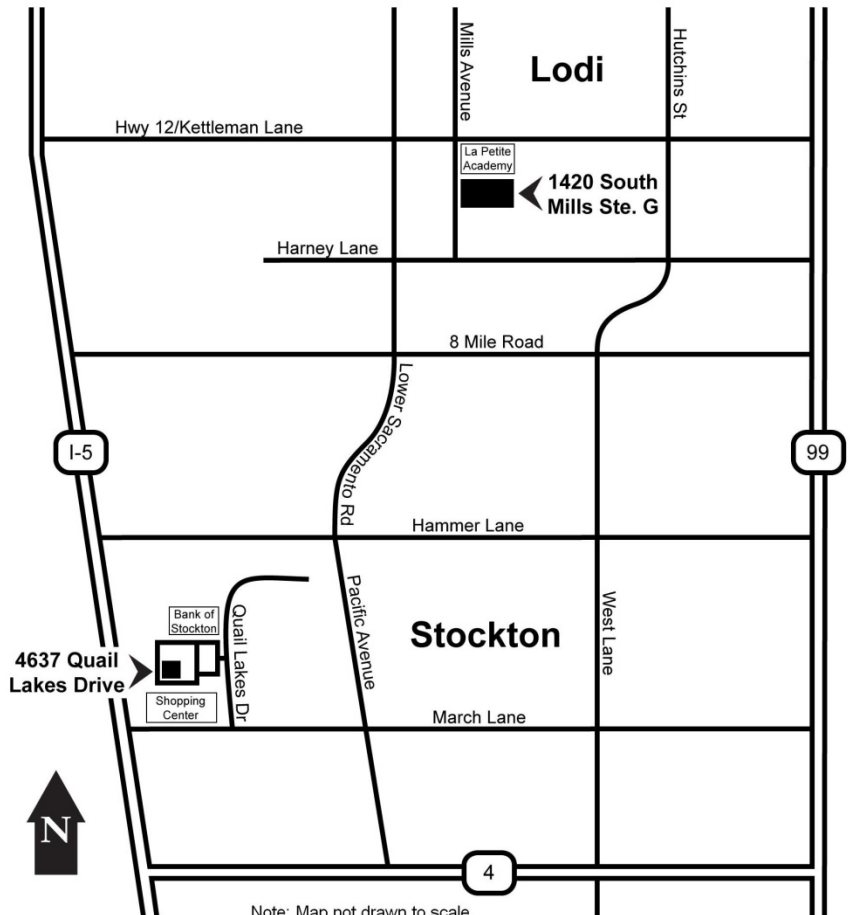
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Note: Map not drawn to scale.