COOK
PERIODONTICS
& DENTAL IMPLANTS

FAX REFERRAL FORM
Fax: 469-888-4317

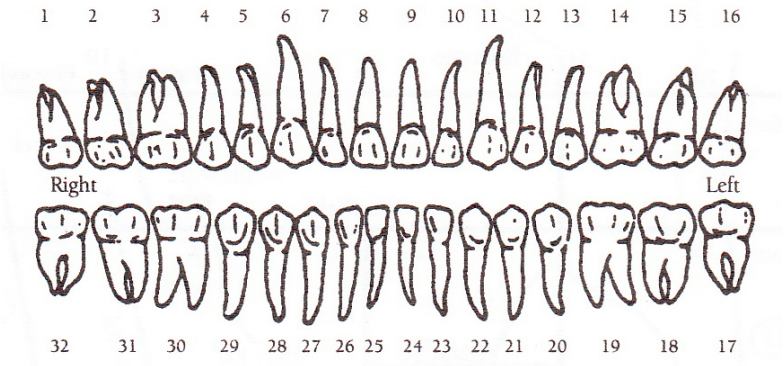
To: Dr. Jeremiah B. Cook Date: _____

From: _____ Phone: _____

Fax: _____

Patient: _____ Phone: _____

☐Patient will contact your office ☐Please contact patient directly.



☐Please perform a comprehensive exam.
☐Please perform a limited exam for: _____
☐Patient has completed initial therapy and requires a surgical evaluation for: _____

Please evaluate for:

☐Crown lengthening ☐Soft tissue graft
☐Guided tissue regeneration ☐Guided bone regeneration
☐Ridge augmentation ☐Sinus elevation UR/ UL
☐Exposure of impacted tooth ☐Biopsy for _____
☐Other _____

☐Please evaluate for dental implants.
Area: _____
Proposed Restorative Plan:
_____
_____
_____
Patient's Primary Concern(s): _____
_____
_____

Comments: _____
_____
_____

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