

# ADVANCED PERIODONTICS IMPLANT CENTER

*Dedicated to Surgical Innovation & Excellence*

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## REFERRAL COMMUNICATION FORM

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Patient Phone \_\_\_\_\_

Referring Doctor \_\_\_\_\_

Appointment on \_\_\_\_\_ Time \_\_\_\_\_

### The Area of Major Concern:

**Periodontics Related:** (Periodontitis, Esthetic, Crown Lengthening, Soft Tissue Augmentation, Smile Line Evaluation and other Pre-Restorative Treatment)

**Dental Implant:** (Sites, Type of Implant Request, Peri-Implantitis)

**Surgical Template:** (Provided by Periodontist; Restorative Dentist)

**Extraction:** (Tooth #, Ridge Augmentation)

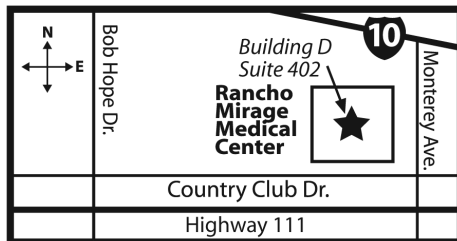
**Other Information:** (Restorative/Prosthetic Treatment Plans, Types and dates of Periodontal Treatment rendered in your office, etc.)

Please forward current X-ray \_\_\_\_\_

This Patient is:  New to my Practice  # of years in Recall \_\_\_\_\_

I would like Dr. to call \_\_\_\_\_  before or  after examination

I would like Dr. to write \_\_\_\_\_  report after exam  report after treatment



### RANCHO MIRAGE MEDICAL CENTER

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