Referral to

☐ **DR. HAMED JAVADI, D.D.S., M.S., F.D.R.C.**

☐ **DR. GREG MEYER, D.D.S., M.S.D.**

Referred by

Name ______________________________________

Address ____________________________________

____

Phone# _____________________________________

e-Mail ______________________________________

Patient

Name__________________________ Date _________

Phone# _____________________________________

e-Mail ______________________________________

Address _____________________________________

____

Reason for referral:

____

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Restorative and other dental needs

(Has it been discussed) ☐ **Yes** ☐ **No**

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Patient History

How long in your practice?

☐ New ☐ Patient since: _________________

Maintenance interval ______ months ☐ Sporadic

Previous periodontal therapy:

☐ None

☐ Root Planing: month ______ year ______

☐ Surgery: month ______ year ______

Recent care in your office:

____

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Additional information or special instructions:

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Radiographs

☐ X-rays will be sent to you before the Examination appointment.

☐ Take new x-rays and return a set to me.

THANK YOU FOR YOUR REFERRAL

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