Tyler Periodontics & Dental Implants

KAYLEIGH E. TEMPLE, DDS, MS ALY KENNEDY, DDS, MS

EMAIL/FAX REFERRAL FORM

Referring Doctor:_____ Date:_____

Patient Name: _____

DOB:_____ Patient Phone: _____

Preferred Provider:

☐ FIRST AVAILABLE ☐ DR. TEMPLE ☐ DR. KENNEDY

☐ Patient will contact your office ☐ Please contact patient directly

☐ Patient is scheduled on _____

REASON FOR REFERRAL:

☐ Periodontal Disease: ☐ Full Mouth ☐ Localized Area _____

☐ Patient has completed initial phase Sc/RP on _____

☐ Recession / Soft Tissue

☐ Grafting Oral Pathology / Biopsy

☐ Frenectomy

☐ Gingivectomy

☐ Crown Lengthening – # _____

☐ Extraction

☐ Ridge Preservation

☐ Dental Implant Therapy – #_____

COMMENTS:

RADIOGRAPHS

☐ FMX

☐ Periapical

☐ Panoramic

☐ Bitewings

☐ CBCT

☐ No radiographs

CONTACT ME

☐ Prior to seeing the patient

☐ After initial evaluation

☐ Letter correspondence

Radiographs – please send digitally to info@tylerperio.com or via mail; please include date radiographs were taken.

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