J. ROBERT FRIEDBERG, D.M.D. & ASSOCIATES

PERIODONTAL ASSOCIATES OF GREATER HOUSTON

9601 Katy Freeway, Suite #360, Houston, TX 77024
Phone: (713) 464-7444 | **Email:** info@friedberg1perio.net

PATIENT REFERRAL FORM

REFERRING DOCTOR INFORMATION

Referring Doctor Name: _____ **Date of Referral:** _____

Practice / Clinic Name: _____ **Office Phone:** _____ **Office Email (for reports):** _____

PATIENT INFORMATION

Patient Name (First & Last): _____ **Date of Birth:** _____

Patient Phone Number: _____ **Patient Email (optional):** _____

Patient has been informed of referral? ☐ Yes ☐ No

REASON FOR REFERRAL / EVALUATION REQUESTED

- ☐ Dental Implants
- ☐ Gum Grafting / Soft Tissue Recession
- ☐ Crown Lengthening
- ☐ Bone Grafting / Sinus Lift
- ☐ Periodontal Evaluation / Gum Disease
- ☐ Endodontic Evaluation / Root Canal
- ☐ Oral Surgery / Surgical Extraction
- ☐ Sleep Apnea / Airway Evaluation

Tooth Number(s) or Specific Area of Concern: _____

RADIOGRAPHS (X-RAYS)

- ☐ Radiographs have been emailed to info@friedberg1perio.net
- ☐ Patient will bring printed radiographs to the appointment
- ☐ Please take new radiographs / CBCT scan at your office

CLINICAL NOTES & MEDICAL ALERTS

Please detail any specific restorative plans, history, or medical alerts (e.g., Blood Thinners, Premedication):