# ClearCare
## Periodontal & Implant Centre


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**Referring Doctor:** _____

☐ Please call patient to schedule a consultation

☐ Scheduled for: Date: _____ Time: _____

Recent Radiograph: ☐ Sent w/Patient ☐ Sent by Mail ☐ Emailed ☐ Please Take

### Patient Information

Name: _____ D.O.B. ___/___/___ (mm/dd/yyyy)

Med Alerts: _____

Phone:(h) _____ (w) _____

### Primary Insurance Information:

Subscriber: _____ D.O.B. ___/___/___ (mm/dd/yyyy)

Carrier: _____ Grp# _____

ID# _____

### Secondary Insurance Information:

Subscriber: _____ D.O.B. ___/___/___ (mm/dd/yyyy)

Carrier: _____ Grp# _____

ID# _____

## Reason for Referral

### Consult & Examination:

☐ Full Exam & Treatment ☐ Specific: _____ ☐ Emergency: _____

### Dental Implant:

☐ Single/Multiple #(s): _____ ☐ Extraction & Immediate Implant: _____

☐ Full Arch Solutions (All-on-4®/ProArch): _____ ☐ Treatment of Peri-Implantitis: _____

### Soft & Hard Tissue Regeneration:

☐ Root Coverage Tooth/Teeth #(s): _____ ☐ Pontic Site Development: _____

☐ Vertical Bone Loss: Site _____ ☐ Bone Graft: Site _____ ☐ Sinus Lift: (R/L) _____

### Perio-Restorative and Pre-Prosthetic Treatment:

☐ Crown Lengthening Tooth/Teeth #(s): _____ ☐ Gummy Smile & Gingivectomy Tooth/Teeth #(s): _____

### Denture:

☐ Tori Removal: Site _____ ☐ Vestibular Plasty: Site _____ ☐ Soft Tissue Recontouring: Site _____

### Adjunctive Orthodontic Procedures:

☐ Pre-orthodontic Assessment: _____ ☐ Frenectomy: _____ ☐ Exposure Tooth/Teeth # (s): _____

### Oral Pathology:

☐ Dx and Management of Oral Lesions: _____ ☐ Biopsy: _____

**Notes:** _____

*We appreciate the opportunity to work with you and aim to return your patient back to your care at their best periodontal health.*

*Thank You for your Referral*