



## REFERRAL INFORMATION

\_\_\_\_\_  
(Patient Name)

Dr. \_\_\_\_\_

### REASON FOR REFERRAL:

- |   |  |
|---|--|
| <input type="checkbox"/> <b>Comprehensive Examination</b> | <input type="checkbox"/> <b>Limited Examination</b>      |
| <input type="checkbox"/> Dental Implant                   | <input type="checkbox"/> Pinhole Surgery (Gum Recession) |
| <input type="checkbox"/> Extraction                       | <input type="checkbox"/> Periodontal Maintenance         |
| <input type="checkbox"/> Crown Lengthening                | <input type="checkbox"/> 3D - CAT Scan                   |
| <input type="checkbox"/> Periodontal Disease              | <input type="checkbox"/> Frenectomy                      |
| <input type="checkbox"/> Scaling & Root Planing           | <input type="checkbox"/> Other                           |

Notes, Tooth # Or Area:

### **Michael Zidile, DDS**

Specialist in Dental Implantology and Periodontology

www.BrooklynPeriodontics.com – [Perio185@gmail.com](mailto:Perio185@gmail.com)

185 Montague Street– 9th Floor, Brooklyn, NY 11201 – (718) 643-1953