REFER A PATIENT

For Medical Providers: Complete the Form Below to Refer a Patient to Pearl Periodontics,
Dr. Alexandra Brummerhop, and Fax to 830-461-5610.

PRACTICE DETAILS

Referring Doctor (Full Name): ______________________

Primary Contact (if not Referring Doctor): ______________________

Today's Date: ______________________

Practice Name: ______________________

Contact Phone Number: ______________________

Email: ______________________

PATIENT DETAILS

Patient Name: ______________________ ______________________

Date of Birth: ________/________/________

Patient Phone #: ______________________ Alt Phone #: ______________________

Patient Email: ______________________

REASON FOR REFERRAL *How Can Pearl Periodontics Help?*

- ☐ Periodontal Evaluation & Treatment
- ☐ Gum Grafting/Root Coverage
- ☐ Gummy Smile Correction
- ☐ Biopsy
- ☐ Ridge Augmentation
- ☐ Sinus Lift
- ☐ Dental Implant Evaluation:

Preferred Implant System? Please specify your preferred Implant System:

Crown Lengthening:

- ☐ Functional
- ☐ Esthetic

Frenectomy:

- ☐ Maxillary
- ☐ Mandibular
- ☐ Labial
- ☐ Lingual

Tooth Exposure:

- ☐ With Bonding
- ☐ Without Bonding

Tooth Extraction:

Extract Tooth/Teeth #: ______________________

Other: (If "other" please specify how we can help.)

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Does Patient Require Pre-medication?

☐ Yes, Pre-medicate | ☐ No, Pre-medication is not required

RESTORATIVE TREATMENT PLAN *Restorative Treatment Plan Details:*
Please specify details below; or fax treatment plan documentation with this referral.

PERIODONTAL TREATMENT COMPLETED IN YOUR OFFICE
Please include patient history below.
Comments/Considerations:

Please include any helpful details that will assist in our understanding of the patient's case below, or include with fax:

Appointment Status ***For Internal Pearl Periodontics Use Only**

Appointment & Follow-Up

STATUS: ___________________________________ ☐ Scheduled ☐ Perio to Call Patient ☐ Patient to Call Perio

Appointment Date:___________________________ Appointment Time: ___________________________

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