Haider Aljewari, BDS, DMD, MS

Board Certified in Periodontics & Implant Surgery

Patient Name: ____________________ Date: ____________

Patient Phone: ____________________ Patient DOB: ____________

Referring Doctor
(first & last name): ____________________ Phone: ____________

Referring Office Email: ________________________________

Dental Insurance Information:

Primary Insurance:

Insured's Name: ____________

Insured's DOB: ____________

Carrier: ____________

Group Number: ____________

ID Number/SSN: ____________

Secondary Insurance:

Insured's Name: ____________

Insured's DOB: ____________

Carrier: ____________

Group Number: ____________

ID Number/SSN: ____________

Referral Information:

The patient is being referred for the evaluation of: ____________________

Tooth or Teeth Numbers: ____________________

- ☐ Comprehensive Periodontal Needs
- ☐ Crown Lengthening / Esthetic Crown Lengthening
- ☐ Implant Evaluation
- ☐ Peri-Implant Disease
- ☐ Tooth Exposure
- ☐ Frenectomy
- ☐ Full Arch Case / Overdenture
- ☐ Biopsy
- ☐ Bone Graft & Regeneration
- ☐ Tissue Grafting & Root Coverage
- ☐ Distal Wedge
- ☐ Extraction & Site Preservation

Comments:

Please Fax or Email Referral and Related Imaging

Radiographs & Related Imagining: Please email over FMX/PANO along with any tooth specific imaging

☐ Emailed to Perio@drdondobend.com ☐ Sent with Patient ☐ Please Take

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