ANDREW C. DREYER, DDS, MS
PERIODONTICS & DENTAL IMPLANTS

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Periodontal & implant referral

Fill in and save this PDF, or print and complete it by hand.

Patient

Patient name

Date of birth

Patient phone

Patient email (optional)

Referring office

Referring dentist

Practice name

Office phone / contact

Reason for referral

- ☐ Periodontal evaluation
- ☐ Implant planning
- ☐ Gum grafting
- ☐ Bone graft / sinus
- ☐ Crown lengthening
- ☐ Other (describe below)

Tooth / teeth or area

Referral date

Clinical question / relevant findings

Restorative goal / timing considerations

Records available for secure transfer

- ☐ Radiographs
- ☐ CBCT
- ☐ Digital scans

Sending the referral

Call (661) 665-0077 for the practice's secure delivery instructions.

This PDF does not submit or upload information. Attach additional records as directed.