Jeffrey J. Glaser DDS, MSD, PA

Periodontics and Dental Implants

Date: _____ /_____ /_____

PLEASE FAX THIS CONSULT TO: 972-964-2263
or EMAIL TO: glaserperio@yahoo.com

Patient Name: ____

Patient Address: ____

LAST **(Please Print)** **FIRST**

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____

Phone: Home (_____)____________ Work (_____)____________ Cell (_____)____________

Insurance: ____

Policy #: ______________________________ Phone: (_____)____________

Subscriber Name: ______________________ Subscriber DOB: _____ /_____ /_____

Subscriber Employer: ____

REASON FOR CONSULT (please check all that apply)

- ❑ Complete Periodontal Exam and Treatment
- ❑ Exam and Treatment Area(s) Noted
- ❑ Dental Implants
- ❑ Crown Lengthening of Area(s) Noted
- ❑ Periodontal Plastic Procedures
  - ___ Anterior Esthetic ___ Ridge Augmentation
- ❑ Bone Grafts
- ❑ Soft Tissue Graft(s)
- ❑ Extractions
  - ___ Impactions ___ Alveloplasty

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

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32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

- ❑ Occlusal Guard
- ❑ Orthodontic Related Treatment
  - ___ Pre-Orthodontic Periodontal Evaluation ___ Tooth Exposure
  - ___ Soft Tissue Grafts ___ Frenectomy

Other: ____

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RADIOGRAPHS

- ❑ Take Radiographs
- ❑ No Current Radiograph Available
- ❑ Radiographs Being Sent
  - ___ Please Return ___ Keep in Your Records

COMMENTS ____

Referral Name: ____

(Please Print)

Referral Signature: ____

Referral Address: ____

Phone: Office (_____)______________ Cell (_____)______________

"Dedicated to quality care for more than 20 years"

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