Houston Oral Healthcare Specialists

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Patient Name

Mr/Mrs/Miss/Ms_____ Date _____

Home Phone_____ Work Phone_____Cell Phone_____

Date of Birth_____ Email Address_____

Referring Dentist_____Phone_____

Referring Hygienist_____Phone_____

Patient being referred for:

- ❑ Periodontal Disease Treatment
- ❑ Recession and Gingival Grafting
- ❑ Functional Crown Lengthening
- ❑ Esthetic Crown Lengthening
- ❑ Tooth Extraction
- ❑ Dental Implant(s)
- ❑ Dental Implants- Full Arch Prosthesis
  - ❑ Maxilla
  - ❑ Mandible
- ❑ Canine Exposure
- ❑ Biopsy
- ❑ Other _____

Tooth Number(s)_____

Comments_____