PERIODONTICS
COLLEGE
OF DENTISTRY

DEPARTMENT OF PERIODONTICS
801 S PAULINA ST, RM 331
CHICAGO, IL 60612
312-996-7374 (Office)
312-996-8878 (Fax)
perioclinic@uic.edu

NEW PATIENT REFERRAL FORM

Date: ________________________________

Patient Name/ D.O.B.*: ____
Home Phone*: ____
Cell Phone: ____
E-mail: ____
Patient's Dental Insurance: ____
How long has the patient been a part of your practice? _____________________________________
Are there any subsidies coming from your organization? ____________________________________

Reason for Referral*:
______ Implants
______ Gingivitis
______ Periodontitis
______ Vertical Defects (GTR)
______ Ridge Augmentation (GBR)
______ Extraction and Socket preservation
______ Orthodontic Exposure
______ Gingivectomy
______ Esthetic Crown Lengthening
______ Implant Failure Management
______ Crown Lengthening
______ Soft Tissue Grafting (Root covering, Post Ortho)

Tooth/Region Number____________

Please include any of the following if available:
Photos ______
Periodontal charting _____
Chart Notes ______
Intra-oral photos ______
X-rays Available: ______
Panoramic _____
Full mouth series_____
CT scan _____

Notes/Comments:
____

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____

Referring Doctor:____

Address: ____

____

Phone: ____

E-mail: ____