



Eduardo Tanur, DDS, MS, MBA
Ruben Ovadia, DDS, MS

Please complete form and fax to (214)503-1003
No cover sheet required

8722 Greenville Ave. Suite 100 • Dallas, TX 75243
T: 214-503-1000 www.dallasimplant.com
F: 214-503-1003 email: info@dallasimplant.com

Specialist Consultation & Treatment Referral Form

Patient's Name: _____
 Patient's Email: _____
 Patient's Contact #: _____
 Referred by Dr.: _____
 Practice Name: _____
 Practice/Office #: _____
 Date of Referral: _____

Please circle area to be treated

UR area	UL area
1 2 3 4 5 6 7 8	9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25	24 23 22 21 20 19 18 17
LR area	LL area

☐ Prefers Spanish Communication

REASON FOR REFERRAL (CHECK ALL THAT APPLY):

Periodontics	Implantology	Esthetic Dentistry	Oral Medicine
<input type="checkbox"/> Persistent Gingival Inflammation/Bleeding <input type="checkbox"/> Pocket Reduction Surgery <input type="checkbox"/> Periodontal Tissue/Bone Regeneration <input type="checkbox"/> Dental Abscess <input type="checkbox"/> Distal Wedge Surgery <input type="checkbox"/> Functional Crown Lengthening <input type="checkbox"/> Determine Restorability/Prognosis <input type="checkbox"/> Frenectomy <input type="checkbox"/> Gingival Recession/Root Coverage <input type="checkbox"/> Lack of Keratinized Gingiva <input type="checkbox"/> Surgical Uncovering Impacted Teeth <input type="checkbox"/> Gingival Hyperplasia/Enlargement <input type="checkbox"/> Tooth Extraction	<input type="checkbox"/> Implant Consultation <input type="checkbox"/> Dental Implant <input type="checkbox"/> Extraction & Immediate Implant <input type="checkbox"/> Extraction & Socket Preservation <input type="checkbox"/> Ridge Augmentation Surgery <input type="checkbox"/> Sinus Lift Bone Augmentation <input type="checkbox"/> Implant Supported Overdenture <input type="checkbox"/> Implant Supported Hybrid <input type="checkbox"/> Implant Supported FPD (Bridge) <input type="checkbox"/> All-On-4 <input type="checkbox"/> Mini Implants/Ortho Anchorage <input type="checkbox"/> CT Scan Guided Implants <input type="checkbox"/> I Will Fabricate Final Abutment <input type="checkbox"/> Please Fabricate Final Abutment	<input type="checkbox"/> Esthetic Crown Lengthening <input type="checkbox"/> Gingivectomy <input type="checkbox"/> Soft Tissue Ridge Augmentation <input type="checkbox"/> Ridge Deformity Correction <input type="checkbox"/> Pontic Site Development <input type="checkbox"/> Irregular Gingival Margins <input type="checkbox"/> Cosmetic Smile Enhancement	<input type="checkbox"/> CT Scan <input type="checkbox"/> Oral Pathology <input type="checkbox"/> Oral Cancer Screening <input type="checkbox"/> Oral Hygiene Instruction <input type="checkbox"/> Hard/Soft Tissue Biopsy <input type="checkbox"/> Smoking Cessation Therapy <input type="checkbox"/> Halitosis Control <input type="checkbox"/> Traumatic Lesions <input type="checkbox"/> Microbiological Testing <input type="checkbox"/> Genetic Testing

Referring doctor's comments and special instructions: _____

Appointment Instructions: ☐ We have called your office when the patient was here and made an appointment with your office.
☐ Please contact patient directly to schedule appointment.

Three Easy Step Approach For A Smooth & Effective Referral Process:

- 1. Your office faxes this referral form (214) 503-1003**
- 2. We call your patient to schedule an appointment**
- 3. We will keep you updated of your patient's progress**

Thank You Very Much For Allowing Us To Share In The Care Of Your Patients !!!