DENTOLOGY REFERRAL FORM

DENTOLOGY BOSTON
330 CONGRESS ST.
BOSTON MA 02210

617-261-6440

DENTOLOGY WOBURN
444 WASHINGTON ST. #301
WOBURN MA 01801

Patient Name: _____ Phone No: _____

Referring Doctor Name: _____ Phone No: _____

Address: _____

Reason for Referral

- ☐ Extraction with immediate implant placement
- ☐ Bone Graft
- ☐ Implant Only
- ☐ Implant and crown
- ☐ Full Arch Implant Bridge
- ☐ OroFacial Pain.
- ☐ Full mouth rehabilitation
- ☐ OSA treatment
- ☐ Orthodontic treatment
- ☐ Other

Tooth #(s) _____ Implant system _____

Have you advised the patient of the possibility of extraction of any teeth? ○ Yes ○ No
If yes which teeth?

_____

_____

Does the patient require premedication? ○ Yes ○ No

Antibiotic used: _____

Radiographs:

☐ Please take/send copy ☐ Patient will bring copy ☐ I will send / Please return

Your Restorative Plans

_____

_____

Comments: _____

_____

_____

Please

☐ Call me before seeing the patient ☐ Call me after seeing the patient

Dentist signature: _____ **Date:** _____