DENTAL PATIENT REFERRAL TO DR. BITA

Please fill out the form below to refer a dental patient to our specialty dental office. We look forward to serving you!

Patient Name _____

Referring Doctor _____

Patient's Phone _____ Patient's Email _____

Appointment Time _____ Appointment Date _____

Referring For: (Indicate tooth number/quads)

- ☐ Perio Eval ____
- ☐ Extraction/Socket Graft ____
- ☐ Recesion ____
- ☐ Frenum Pull ____
- ☐ Laser Periodontal Tx/LANAP ____
- ☐ Sinus Lift/Ridge Aug ____
- ☐ Inadequate Attached Gingiva ____
- ☐ Digital Wedge/Gingivectomy ____
- ☐ Crown Lengthening Sites:
  - ____ ☐ For restoration
  - ____ ☐ For Smile Design/Gummy Smile
- ☐ Dental Implant(s) ____
- ☐ Biopsy ____
- ☐ All on X ____