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NEW PATIENT FAX REFERRAL FORM
Please fax to (910) 256-8449
Please mail if fax is unavailable

PATIENT INFORMATION: **DATE:** _____
REFERRED BY: _____
Patient Name: _____ **Home #** _____ **Mobile #** _____
Address: _____
☐Been Patient of Record Since? _____ ☐Compliant with Regular Recares?
☐New Patient / 1st Visit Date? _____ ☐3 mo ☐4 mo ☐6 mo
☐ Non-Compliant - Only on PRN basis.

HEALTH:
☐**Healthy Patient** – No Health Concerns. **Is Patient A Smoker**? ☐Yes ☐No
☐**Health Concerns** – Indicate Below:
☐BP Controlled with: _____
☐Diabetes (Check One…) ☐Insulin Dependent ☐Oral Medication(s)
☐Blood Thinners ? (Check One…) ☐Aspirin ☐Plavix ☐Coumadin ☐Warafin
☐Osetopenia/Osteoporosis (Check One…) ☐Fosamax ☐Boniva ☐Actonel ☐Reclast ☐Other? _____
☐**Medications:** *(Please List or Send Copy)* _____
☐**NKDA** ☐**Drug Allergies? (***Please List)* _____
☐**PREMED** What Med? _____ Reason for Premed? _____

PERIODONTAL STATUS: (Please Include Copy of Periodontal Charting(s) current and ≥ 1 year.)
☐No Disease
☐Gingivitis: ☐Localized / ☐Generalized ☐Mild ☐Moderate ☐Severe
☐Periodontitis: ☐Localized / ☐Generalized ☐Mild ☐Moderate ☐Severe

REFERRED FOR:
☐**Periodontal issues** _____
☐**Scaling & Root Planning**
☐**Implants:** ☐Single Tooth # _____ ☐Multiple Teeth # _____
☐Teeth Still Present ☐Teeth Missing (If Missing How Long?) _____
☐Please Note Reason for Extraction: ☐Caries ☐Fracture ☐Endo Failure
☐Esthetic Area? ☐#'s 3-14 ☐High Smile Line?
☐Is Restorative Height an Issue? ☐Yes ☐No
☐Over Denture Case: ☐Locators ☐x2 ☐x3 ☐x4
☐Plan for New Denture ☐Use Existing Denture(s)
Current Dentures Fabricated When? _____
☐**Crown Lengthening #**_____
☐**Soft Tissue/Connective Tissue Grafting #**_____
☐**Other:** _____

ADDITIONAL NOTES… Anita Goens _____
_____

RADIOGRAPHS & STUDY MODELS:
☐Prior X-rays Available ☐PA Date? _____ ☐FMX Date? _____ ☐Panorex Date? _____
☐Radiographs will be Sent: ☐Included with referral form ☐Via Mail ☐Via e-mail
(anita@phylliscook.com *or* brenda@phylliscook.com)
☐Study models and/or diagnostic wax-up (circle accordingly)

TREATMENT OPTIONS DISCUSSED WITH PATIENT:
Please Describe: (include list if necessary) _____
_____
_____
Any other restorative needs? _____

APPOINTMENT STATUS:
☐**Dr. Cook's office to call the patient and coordinate appointment.**
☐**Scheduled appointment by phone while patient was in the office Date:**_____ **Time:**_____