PERIODONTAL
PATIENT REFERRAL FORM

Patient Information

Name: ____

Birth date: ________________________ Gender: ☐ M ☐ F

Address: ____

____

Phone: ____

Dental Ins: ____

Medical Ins: _______________________________________

ID #: ____

Preferred Dentist

☐ First available

☐ Dr. Robert Bitter

Referred by:

Name: ____

Facility: ______________________________________

Phone: ____

Radiographs:

___Enclosed ___Patient will bring ___None provided ___Will be sent ___On AxiUm

To transfer patient records and radiographs electronically, please visit the following URL: https://sdm.siue.edu/xraydropboxfp/uploadxrays.php. Please include your office name/phone number, patient name/date of birth, and date of radiographs.

Patient referred for:

____Comprehensive periodontal exam

____Implants in areas indicated below

____Limited periodontal consult (please specify below)

____Other (please specify below)

Specific comments: ____

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Restorative plan: ____

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Patient medical history or special considerations: ______________________________________

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