In addition to the referral form, please email the patient's most recent records and recording dates.

| ***Referral Reason:*** | ***Please attach their current/most recent:*** | | | |
|---|---|---|---|---|
| Implants | Pano | | | |
| Sinus Elevation | Pano | | | |
| Exposure | Pano | | | |
| Frenectomy | Pano | | | |
| Wisdom Teeth | Pano | | | |
| Crown Lengthening | | FMX/Pano | Additional X-Rays | |
| Surgical Extractions | | FMX/Pano | Additional X-Rays | |
| Bone Graft | | FMX/Pano | Additional X-Rays | |
| Sinus Elevation | | FMX/Pano | Additional X-Rays | |
| Bone Graft | | FMX/Pano | Additional X-Rays | |
| Sinus Elevation | | FMX/Pano | Additional X-Rays | |
| Periodontal Eval | | FMX/Pano | Additional X-Rays | Perio Charting |
| Perioscope | | FMX/Pano | Additional X-Rays | Perio Charting |
| Tissue Grafts | | FMX/Pano | | Perio Charting |

NOTE: If the required images are ***out of date***,
please send the out of date films in addition to their most recent X-Rays.

THANK YOU

LOWELL STREET
Dental Implant & Surgical Center

GREGGORY S. WILDE, DDS
www.LowellStreetCenter.com
**Email: Info@LowellStreetCenter.com**
P (360) 692-0300 | F (360) 698-2988

Date: ____________________

Referring Doctor: ____________________ Phone: ____________________

Patient's Name: ____________________ DOB: ____________________

Phone (Cell): ____________________ Phone (Home): ____________________

Patient's Email: ____________________

- ☐ Crown Lengthening
- ☐ Gingival Graft
- ☐ Frenectomy
- ☐ Ridge Augmentation
- ☐ Implants
- ☐ IV Sedation
- ☐ Co-Diagnosis
- ☐ Pocket Reduction
- ☐ Oral Pathology
- ☐ Bone Graft
- ☐ Impacted Tooth Exposure
- ☐ Perioscope
- ☐ Periodontal Disease
- ☐ Wilckodontics
- ☐ Cosmetic Gingival Contouring
- ☐ General Extraction / Wisdom Teeth
- ☐ Temporary Anchorage Device (TAD)
- ☐ 3-D Dental Imaging

| (R) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | (L) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | |

| A | B | C | D | E | F | G | H | I | J |
|---|---|---|---|---|---|---|---|---|---|
| T | S | R | Q | P | O | N | M | L | K |

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☐ Comprehensive Periodontal Examination: ☐ Limited Periodontal Examination:

Location and nature of problem: ____________________

____________________

____________________

***Diagnostic Documentation:***

- ☐ Full-mouth radiograph (dated) enclosed
- ☐ Periodontal Charting (dated) enclosed
- ☐ Lowell Center will take new x-rays & send copy

***Desired Referral Outcome:***

- ☐ Diagnosis and treatment at Lowell Street Center
- ☐ Diagnosis and alternating office treatment
- ☐ Diagnosis only
- ☐ Call referring doctor prior to treatment

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☐ Extraction/Bone Graft – Teeth #: ____________________

In preparation for: ☐ Implant ☐ Bridge ☐ Denture

☐ Implant Evaluation

Area to be restored with implants: ____________________

Types of restorations planned: ____________________

☐ Has patient been seen in our office before: ☐ Yes ☐ No

☐ Special Comments: ____________________

3594 NW Lowell Street • PO Box 1970 • SILVERDALE, WA 98383

# Silverdale Office Map