Saxony Medical Building
345 Saxony Road, Suite 203
Encinitas, CA 92024

Patient Name ___________________________ Date ____________

Phone #s H ___________________________ W _______________

Referring Doctor _________________________

My Appointment
Date ________________
Time __________________

Circle Tooth / Area

Recent Full Mouth Radiographs: □ Accompany Patient  □ Mailed Date ________________
□ Patient does not have radiographs, take as needed

How long has the patient been in your practice? ________________________________

REFERRED FOR:
□ Complete Periodontal Evaluation
□ Limited Consultation
□ Implant Consultation
□ Crown Lengthening
□ Mucogingival Concern
□ Aesthetic Surgery
□ Other

Comments: ____________________________________________________________

______________________________________________________________

INSTRUCTIONS FOR PATIENTS
Please call for an appointment
If you are taking medications, please bring a list of them with you
Minors must be accompanied by a parent or guardian
Fees are payable at the time of service

□ E Mail Report to Referring Doctor at: ____________________________

WHITE - Give to Patient

YELLOW - Keep in YOUR Patient Chart