four corners periodontics, p.c.
mark s. blue, dds

Please email patient referral form to healthygums@drmarkblue.com

Patient Name:_____**Date of Birth:** _____

Patient Address:_____

Patient Phone #: _____**Email Address:**_____

Referring Doctor:_____**Date of Referral**: _____

Referred for:

☐ **Gingival Recession:** Teeth#(s)_____
(Please send clinical photographs of involved area and periodontal charting, if possible)

☐ **Periodontal Disease:** UR☐ LR☐ UL☐ LL☐ Individual Teeth #(s)_____
Date of Previous SRP: _____
(Please send clinical radiographs and most current periodontal charting, if possible)

☐ **Tooth Extraction:** Teeth #(s)_____ Reason for Extraction: _____

☐ **Dental Implants:** Missing Teeth#(s)_____ Date of extraction(s):_____

☐ **Crown Lengthening:** Teeth #(s)_____ Reason for CL: _____
(Please send clinical radiographs and most current periodontal charting if possible)

☐ **Perio/Ortho:** Unexposed Tooth Uncovery #_____ Extract Primary Teeth #(s)_____
(Please send PANO and/or CBCT)

☐ **Other/Notes/Restorative Plans:**

Special Medical Considerations:

Premedication: Yes☐ No☐

Insurance Information:

Primary Subscriber: _____ **DOB:** _____ **Member ID:** _____

Insurance Company: _____ **Group#:** _____

Insurance Claims Address: _____

Insurance Phone Number: _____

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