SAN FRANCISCO
RECONSTRUCTIVE PERIODONTICS

Referral to

☐ **HAMED JAVADI, D.D.S., M.S.**

☐ **GREG MEYERS, D.D.S., M.S.D.**

Referred by

Name _____

Address _____

_____

Phone# _____

e-Mail _____

Patient

Name_____ Date _____

Phone# _____

e-Mail _____

Address _____

_____

Reason for referral:

_____

_____

Restorative and other dental needs

(Has it been discussed) ☐ **Yes** ☐ **No**

_____

_____

Patient History

How long in your practice?

☐ **New** ☐ **Patient since:** _____

Maintenance interval _____ **months** ☐ **Sporadic**

Previous periodontal therapy:

☐ **None**

☐ **Root Planing:** **month** _____ **year** _____

☐ **Surgery:** **month** _____ **year** _____

Recent care in your office:

_____

_____

Additional information or special instructions:

_____

_____

_____

Radiographs

☐ **X-rays will be sent to you before the Examination appointment.**

☐ **Take new x-rays and return a set to me.**

THANK YOU FOR YOUR REFERRAL

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