Studio City Center for
Implant & Periodontal Care
Mahasti Saghizadeh D.D.S., M.S.
Diplomate, American Board of Periodontology

Fax Referral Form-No cover sheet require

Please fax to (818)760-4076

This is to introduce Mr./Ms. _____ to your office.
Patient phone number (home) _____ (work) _____ (mobile) _____
Referring doctor _____ Phone _____ Date _____
Areas of Concern _____

Suggested treatment:

___ Comprehensive periodontal evaluation and treatment
___ Limited oral evaluation and treatment of sites: _____
___ Crown lengthening
___ Dental implants
___ Esthetic periodontal evaluation and treatment
___ Consult only
___ Other _____

Radiographs: Please give a copy of the most recent radiographs to your patient for their initial visit.

___ Prior Radiographs are available upon request
___ No new radiographs available, please take

Scaling and Root planning:

___ Has been performed on _____
___ Will be performed on _____
___ Please perform at your office
___ Only recall was done on _____

Restorative Treatment Plan:

___ is complete
___ is established
___ is pending outcome of periodontal consult
Treatment plan: _____

Scheduling:

___ Patient is scheduled in your office on Day _____ , Date _____ , and Time _____
___ Patient would like you to call and make an appointment as soon as possible.
___ Patient will call your office to schedule an appointment . If patient does not call, please call and schedule in a week

Comments: _____
_____
_____

Thank you for giving us the opportunity to be part of your patient's dental care.

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