ROOT™
Periodontal and Implant Center

PERIODONTAL + DENTAL IMPLANT REFERRAL

EMAIL TO referrals@ROOTdfw.com

PLEASE CHOOSE LOCATION AND SURGEON THAT PATIENT IS BEING REFERRED TO: DATE: _____

DOCTORS:

- ☐ Dr. Amit M. Patel
- ☐ Dr. Asfia Husain
- ☐ Dr. Kimberly Sheppard
- ☐ Dr. Minny Li
- ☐ Dr. Pooria Fallah
- ☐ Dr. Youstina Mikhail
- ☐ Any Provider

LOCATIONS:

☐ **Dallas/Highland Park**
4514 Cole Ave, #930
Dallas, TX 75205
(214) 624-7668 (ROOT)

☐ **Frisco**
6340 Preston Rd, #100
Frisco, TX 75034
(469) 489-7668 (ROOT)

☐ **Flower Mound**
651 Cross Timbers Rd, #102
Flower Mound, TX 75028
(972) 434-8050

☐ **Argyle**
100 Country Club #104
Argyle, TX 76226
(940) 489-7668 (ROOT)

☐ **Carrollton**
2440 N. Josey Ln, #202
Carrollton, TX 75006
(972) 242-7603

☐ **Denton**
1601 N. Elm St, Ste B
Denton, TX 76201
(940) 566-7021

☐ **Fort Worth/Keller**
3409 N Tarrant Pkwy, #117
Fort Worth, TX 76177
(817) 242-7668 (ROOT)

THIS IS TOINTRODUCE: _____ PATIENT PHONE: _____

REFERRING DOCTOR: _____ OFFICE NAME: _____ OFFICE PHONE: _____

- ☐ AN APPOINTMENT HAS BEEN RESERVED ON: _____
- ☐ PLEASE CALL MY PATIENT TO SCHEDULE AN APPOINTMENT
- ☐ MY PATIENT WILL BE CALLING YOU TO SCHEDULE AN APPOINTMENT

MY PATIENT REQUIRES A COMPLETE EXAMINATION FOR *(PLEASE SPECIFIY SITE)*:

☐ Periodontal Evaluation	☐ Bone Graft	☐ Emergency
☐ Implant Evaluation	☐ Peri-implantitis (LAPIP)	☐ Exposure of Impacted Tooth
☐ Extraction	☐ Oral Pathology / Biopsy	☐ 3-D CT Scan
☐ Soft Tissue Graft/Recession Treatment	☐ Crown Lengthening	☐ Wisdom Teeth Extraction
☐ Guided Tissue Regeneration (GTR)	☐ Cosmetics	☐ Other
☐ LANAP	☐ SRP/Perioscopy	

COMMENTS (PLEASE INCLUDE **RELATED** TREATMENT COMPLETED IN YOUR OFFICE IF INDICATED):

RADIOGRAPHS AVAILABLE: ☐ YES ☐ BEING SENT ☐ PATIENT BRINGING ☐ WOULD LIKE US TO TAKE

TYPE: _____ DATE TAKEN: _____

I PLAN THE RESTORATIVE/PROSTHETIC/ORTHODONTIC/ENDODONTIC/ORAL SURGERY TREATMENT:

MEDICAL HISTORY CONCERNS: _____ ANTIBIOTIC PROPHYLAXIS: ☐ YES ☐ NO

PLEASE CALL ME: ☐ BEFORE CONSULTATION ☐ AFTER CONSULTATION