

PLEASE CHOOSE LOCATION AND PRACTITIONER PATIENT IS BEING REFERRED TO:

DOCTORS:

- Dr. Amit M. Patel
- Dr. Steven Alspach
- Dr. Pooria Fallah Abed
- Dr. Asfia Husain
- Dr. Kimberly Sheppard
- Any Provider

LOCATIONS:

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Dallas/Highland Park
4514 Cole Ave, #930
Dallas, TX 75205
(214) 624-7668 | <ul style="list-style-type: none"> <input type="checkbox"/> Frisco
6340 Preston Rd, #100
Frisco, TX 75034
(469) 489-ROOT | <ul style="list-style-type: none"> <input type="checkbox"/> Flower Mound
651 Cross Timbers Rd, #102
Flower Mound, TX 75028
(972) 434-8050 |
| <ul style="list-style-type: none"> <input type="checkbox"/> Carrollton
2440 N. Josey Ln, #202
Carrollton, TX 75006
(972) 242-7603 | <ul style="list-style-type: none"> <input type="checkbox"/> Denton
1601 N. Elm St, Ste B
Denton, TX 76201
(940) 566-7021 | <ul style="list-style-type: none"> <input type="checkbox"/> Fort Worth/Keller
3409 N Tarrant Pkwy, #117
Fort Worth, TX 76177
817-242-ROOT |

THIS IS TO **INTRODUCE:** _____ PATIENT PHONE: _____

FROM: _____ OFFICE NUMBER: _____ DATE: _____

- 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 **COMPLIMENTARY** COMPLETE EXAMINATION FOR (PLEASE SPECIFY SITE):

<input type="checkbox"/> Periodontal Evaluation	<input type="checkbox"/> Bone Graft	<input type="checkbox"/> Emergency
<input type="checkbox"/> Implant Evaluation	<input type="checkbox"/> Peri-implantitis (LAPIP)	<input type="checkbox"/> Exposure of Impacted Tooth
<input type="checkbox"/> Extraction	<input type="checkbox"/> Oral Pathology	<input type="checkbox"/> 3-D CT Scan
<input type="checkbox"/> Soft Tissue Graft/Recession Treatment	<input type="checkbox"/> Crown Lengthening	<input type="checkbox"/> Wisdom Teeth Extraction
<input type="checkbox"/> Guided Tissue Regeneration	<input type="checkbox"/> Cosmetics	<input type="checkbox"/> Other

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