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Implants and Periodontics

Dental Implant/Periodontal Referral Fax Sheet

Fax: 210.826.6733

Date: _____ Referring Doctor: _____

Patient Name: _____ D.O.B.: _____

Address: _____ City/State/Zip: _____

Telephone Numbers: Home: _____ Work: _____ Cell: _____

Reason for Referral: **Implants** **Perio** **Tissue Grafting** **Crown lengthening**

Implant/s numbers/areas: _____

Periodontitis: Full-mouth Limited areas: _____

Recession areas/teeth numbers: _____

Crown lengthening areas/teeth numbers: _____

Other: _____

Radiographs being sent:

FMX BWXR PA PANO Date taken: _____

Please take necessary radiographs.

Stents or models being sent? Yes No

Date of most recent periodontal charting: _____ Is this being sent? Yes No

Appointment status:

An appointment was made by our office. Date: _____ Time: _____

Please call patient.

Patient will call for an appointment.

Notes: