Ben Y. Choi, DMD MSD

Periodontist and Dental Implant Specialist

Thank you for referring your patient to us for their surgery. We assure you they will receive the highest standard of care throughout their treatment.

Patient's Name _____ Patient's DOB ___ / ___ / ___

Patient's Email _____ Patient's Phone# _____

Referring Doctor _____ Doctor's Office _____

Office Phone# _____ Date Referred ___ / ___ / ___

Patient is being referred for

ALL-ON-X	Biopsy (soft tissue)	Botox	Crown Lengthening
Implants	Periodontal Disease	Perio Evaluation	Sinus Augmentation
Soft Tissue Graft	Wisdom Teeth	Other:	

Implants Preference: ☐ Zimmer ☐ Straumann ☐ Nobel ☐ Other

Comments / Area of Special Concern

Outline any restorative plans you have for the patient at this time

Most Recent Treatment Date:

☐ Prophylaxis Most Recent Date: ___ / ___ / ___ Frequency: ☐ 3month ☐ 4month ☐ 6month

☐ Scaling & Root Planing Most Recent Date: ___ / ___ / ___

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