MOSAIC PERIODONTICS

Patent Referral

To schedule an appointment please call: 801-207-7070

Patient: _____ Phone: _____

Referring Doctor: _____ Phone: _____

Date: _____

Please check all that apply:

Implants	Comprehensive Periodontal Evaluation
Recession	Sinus Lift
Extraction	Crown Lengthening
Sinus Lift	Frenectomy
Oral Pathology	Ortho Exposure

Teeth Numbers: _____

DOCTORS COMMENTS:

Is this an emergency? Yes No

Radiographs:

_____ E-mailed to info@mosaicpeiro.com _____ Sent w/ patient _____ Please take x-rays

PLEASE SEND THIS FORM AND A COPY OF ALL X-RAYS WITH THE PATIENT

Dear Patient: Thank you for choosing Mosaic Periodontics. At your first appointment our doctor will perform a thorough examination, make a diagnosis, explain your condition, and create a treatment plan specific to your needs. This information will be shared with your dentist to facilitate continuous care between our offices. As part of the plan the doctor will present a treatment time frame and our treatment coordinator will be available to discuss fees and insurance coverage. We are passionate about periodontics and cosmetic implant dentistry and look forward to welcoming you to our practice.

Appointment: Date_____ Time _____

Mosaic Periodontics Address: 166 E. 5900 S. B101 Murray, Utah 84107