

Lauren Brownfield, D.D.S., M.S.

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Date: _____

Referring Doctor Information

Referred by: Email: Telephone:

Patient Information	
First Name:	<input type="text"/>
Last Name:	<input type="text"/>
Telephone (home):	<input type="text"/>
Telephone (work):	<input type="text"/>
Telephone (other):	<input type="text"/>

I am referring this patient for:

- Dental Implants - Placement Evaluation Site / Tooth #'s:
- Periodontal - Complete Evaluation & Treatment Quadrant(s): UL UR LL LR All
- Periodontal - Limited Evaluation & Treatment Site / Tooth #'s:
- Periodontal - Cosmetic Evaluation & Treatment Quadrant(s): UL UR LL LR All
- Crown Lengthening Site / Tooth #'s:
- Bone Regeneration / Ridge Augmentation Site / Tooth #'s:
- Recession / Tissue Grafting Site / Tooth #'s:
- Emergency / Abscess Site / Tooth #'s:
- Other

Have you advised the patient of the possibility of extraction of any teeth? Yes No

If yes, which tooth #'s:

Periodontal Treatment Performed by Referring Office Already

- Scaling and Root Planing: Quadrant(s): UL UR LL LR All
- Periodontal Maintenance
- Other

Radiographs

- Are being forwarded to the practice Will accompany patient Are available in our office
- If needed, take x-rays and return a copy to our office

Case Planning

- Please contact before examination Please contact after examination to discuss treatment options

I prefer to be contacted by: Telephone Secure email Fax (Number)