Ocala Periodontics & Dental Implants

Jamie N. Amir BDS, MS

4600 SW 46th Court, Building 200, Suite 360, Ocala, Florida 34474 | Phone (352) 229-8686

Please EMAIL to office@ocalaperio.com or FAX to (352) 433-4497

Please visit our website at www.ocalaperio.com

Patient Information

Date of Referral _____/_____/_____

Name: Mr. / Ms. / Mrs. / Dr. _____ D.O.B._____/_____/_____

Telephone: cell / home / work (_____) _____ Email:_____

- ☐ Patient is scheduled in your office on_____/_____/_____at _____:_____ am / pm
- ☐ Patient will contact your office
- ☐ Please contact patient to schedule

Referring Doctor

Dr. _____ Email: _____

Office Phone:_____ Office Fax: _____

☐ Please call me to discuss this case before / after your examination

Areas of Concern

- ☐ Teeth #'s _____
- ☐ Arch(es) _____
  - ☐ Periodontal Disease
  - ☐ Recession Treatment
  - ☐ Crown Lengthening
  - ☐ Root Reshaping
  - ☐ Extraction
  - ☐ Dental Implants
  - ☐ Sinus Augmentation
  - ☐ Ridge Augmentation
  - ☐ Tooth Exposure
  - ☐ Frenectomy
  - ☐ LANAP/LAPIP
  - ☐ CT Scan - please complete CT prescription form
  - ☐ Other _____

Restorative Plans

1. _____
2. _____
3. _____
4. _____

Radiographs Available:	Date Taken
☐ FMX	_____/_____/_____
☐ BWX	_____/_____/_____
☐ PANO	_____/_____/_____
☐ PAs	_____/_____/_____

Sending by:

- ☐ Email
- ☐ Mail
- ☐ Patient Bringing

Periodontal Treatment Completed in Your Office

	Dates Completed
☐ Debridement	_____/_____/_____
☐ Scaling & Root Planing	_____/_____/_____
☐ Periodontal Maintenance	_____/_____/_____

Notes

_____

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_____

PLEASE SEE MAP ON REVERSE FOR DIRECTIONS TO OUR OFFICE