BAY AREA
IMPLANTS & PERIODONTICS

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☐ Dr. Fabrice Gallez ☐ Dr. Elena Sanz Miralles ☐ Dr. Michael Ha ☐ First Available

REFERRING DOCTOR: _____ **DATE:** _____

INTRODUCING:

Patient's Name: _____

Patient's Phone: _____

Patient's Email: _____

REASON FOR THE REFERRAL:

☐ Gingival recessions: _____ ☐ Crown lengthening: _____

☐ Implant consultation: _____ ☐ All-on-X consultation: _____

☐ Other: _____

_____

_____

_____

_____

HISTORY OF SRP'S (IF APPLICABLE): _____

REFERRING DOCTOR WOULD LIKE TO:

Discuss the case with doctors ☐ By phone ☐ By email

BEFORE the consultation appointment

RADIOGRAPHS:

☐ Referring doctor will send by email ☐ Please take in your office

☐ FMX Date taken: _____

☐ PA Date taken: _____