Martha H. Sanger DDS, Inc.

Practice Limited to Periodontics with Services in Dental Implants

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Phone: (661) 395-3115, Fax: (661) 327-0679
www.sangerdds.com, E-mail: sangerdds@yahoo.com

Date _____

Patient Name: _____

Referring Doctor: _____

Right															Left
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32	31	30	29	28	27	26	25		22	23	22	21	20	19	18	17

Please evalute for:

- ❑ Comprehensive Periodontal Exam
- ❑ Extractions
- ❑ Sinus Lift
- ❑ CT Scan
- ❑ Implants
- ❑ Crown Lengthening
- ❑ Soft Tissue Gafting
- ❑ Ridge Augmentation

Other: _____

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Radiographs:

❑ Send by Mail ❑ Send by E-mail ❑ Send with Patient ❑ Take New Films

PLEASE BRING THIS REFERRAL CARD WITH YOU TO YOUR APPOINTMENT.

Form IF