MICHAEL A SHER, DMD, MS
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PHONE 440.546.9333
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TeamSher@SherSmiles.com

ORTHODONTIC REFERRAL

Date: ______________________________

Introducing: ______________________________

Date of Birth: ______________________________

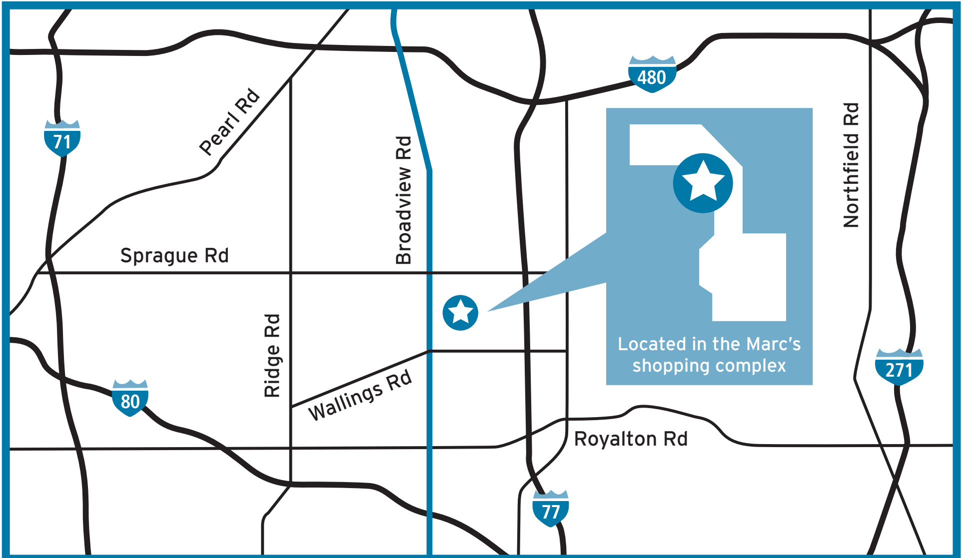
Phone Number: ________________ Email Address: ________________

Referred By: ______________________________

Comments: ______________________________

____

____



Call 440.546.9333 to schedule your complimentary appointment

DEENA SHER, DMD, MS
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PERIODONTIC REFERRAL

Date: ______________________________

Introducing: ____________________ Date of Birth: ____________________

Who is being referred for:

☐ Full mouth periodontal examination and treatment

☐ Evaluation and treatment of localized areas

- ☐ Crown lengthening/exposure ____________________
- ☐ Soft tissue/recession ____________________
- ☐ Extraction ____________________
- ☐ Implant ____________________
- ☐ Pathology ____________________
- ☐ Other ____________________

Areas of Concern:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Remarks: ______________________________

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PERIODONTAL TREATMENT COMPLETED IN YOUR OFFICE TO DATE:

- ☐ Prophylaxis • Recall Interval _____ months • Date of Service ___/___/___
- ☐ SRP • Date of Service ___/___/___

Radiographs: ☐ Given to patient ☐ Sent/emailed ☐ Please take as needed

Referred By: ______________________________

Appointment: ______________________________