SHER SMILES
PERIODONTICS & ORTHODONTICS

ORTHODONTIC REFERRAL

MICHAEL A. SHER, DMD, MS
www.SherSmiles.com

Date: _____

Introducing: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Referred By: _____

Comments: _____

_____

_____

_____

_____

_____

Schedule your **complimentary** orthodontic consultation at www.SherSmiles.com

LYNDHURST

29001 Cedar Road, Suite 400
Lyndhurst, OH 44124

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FAX 440.684.4869

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SHER SMILES
PERIODONTICS & ORTHODONTICS

PERIODONTIC REFERRAL

DEENA SHER, DMD, MS
LAWRENCE S. FRANKEL, DMD, MS
www.SherSmiles.com

Date: _____

Introducing: _____

Who is being referred for:

☐ Full 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: _____

_____

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

Referred By: _____

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