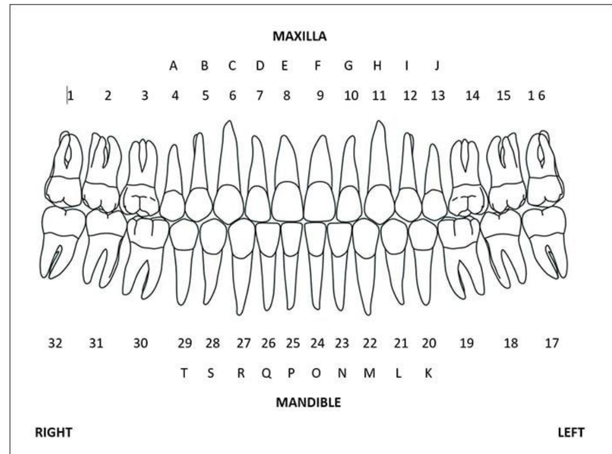
JEFFREY M. GARCIA DDS, MS
KINAN M. AL-BITAR DDS, MS

Date: ________________

Patient Name: ____________________________ **Patient Phone Number**: _________________

Reason for Referral:

Full Mouth Examination__________
Recession_____________________
Implant________________________
Extractions____________________
Recession____________________
Crown Lengthening____________
Ortho-Perio__________________
Other________________________



History of Periodontal Therapy:

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Restorative Considerations:

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Radiographs: Full Mouth Panoramic Bite Wings Periapical CBCT

Additional Comments Relevant to this referral:

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Referring Doctor: ________________________________

WAUKESHA
2316 N. GRANDVIEW BLVD.
WAUKESHA, WI 53188
262-547-1877

MUKWONAGO
400 BAY VIEW RD STE K
MUKWONAGO, WI 53149
262-363-1933

Please send or fax referral to: 262-521-3476 **OR** office@lakecountryperio.com