



Christopher Brett, DDS, MS

Excellence in Dental Implants & Periodontics

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Date: _____

This is to Introduce

Patient's Name: _____

Patient's Telephone: _____

Patient's Address: _____
Street City Zip

Provider: Dr. Christopher Brett

Referred by Dr. _____

Telephone: _____

☐ Please call patient to schedule appointment ☐ Patient will call to schedule

Reason for referral: ☐ Eval for Implant(s) _____

☐ Eval for Full Arch Implants _____

☐ Eval of Implant Problem _____

☐ Perio Exam ☐ Complete ☐ Limited _____

☐ Recession _____

☐ Crown Lengthening _____

☐ Other _____

Please indicate particular areas of concern, restoration plan, implant or esthetic areas, etc.

Radiographs: ☐ Please take & send copy

Films Available: ☐ Full mouth ☐ Limited ☐ Panoramic

Being Sent: ☐ By mail ☐ By Email ☐ With patient

Please call me: ☐ Before Seeing Patient ☐ After Seeing Patient

*Please detach and give top copy to patient.
Please email referral to littleton@theperiodocs.com.*



Periodontal Associates
The Dental Implant Team
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