Justin Tullis DDS, MS
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REFERRAL FORM

Referred by: _____

Reason for Referral:

- ☐ Comprehensive Perio Evaluation
- ☐ Dental Implants:
  - ☐ Site preparation #_____
  - ☐ Implant placement #_____
  - ☐ Peri-Implantitis #_____
  - ☐ Sinus augmentation_____
- ☐ Soft Tissue Augmentation _____
- ☐ Extractions/oral surgery_____
- ☐ Biopsy_____
- ☐ CBCT Imaging_____
- ☐ Limited Evaluation. Area of concern: _____

Additional Comments/Requests:_____

_____

Previous Periodontal Therapy Completed:

- ☐ _____ Date completed:_____

Radiographs:
Please send most recent radiographs. We will expose supplemental images as needed for diagnosis and treatment planning, including FMX if needed.

Patient Contact Info:

Name:_____ Phone:_____

Email:_____