

Capitol PERIODONTAL

Periodontics & Implant Dentistry

www.capitolperiodontal.com

REFERRAL FORM

Date: _____

Specializing in Periodontology & Dental Implantology

Patient Name _____

Home # _____ Work # _____

Referred by _____ Phone # _____

Please provide: Full Periodontal Evaluation Implant Consultation
 Specific Area or Treatment _____

IMPORTANT: Current Radiographs: Sent By Mail With Patient

YOUR APPOINTMENT: Date _____ Time _____

Please check a location

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Sacramento Office
1810 Professional Drive
Sacramento, California 95825
(916) 971-3461
(916) 973-9830 Fax | <input type="checkbox"/> Laguna Office
9309 Office Park Circle, Suite 110
Elk Grove, California 95758
(916) 684-3379
(916) 684-4106 Fax | <input type="checkbox"/> Roseville Office
2428 Professional Drive, Suite 100
Roseville, California 95661
(916) 786-6585
(916) 786-7542 Fax | <input type="checkbox"/> Folsom Office
2535 East Bidwell, Suite 150
Folsom, California 95630
(916) 984-1109
(916) 984-1764 Fax |
|--|--|---|---|

- | | | |
|---|---|--|
| <input type="checkbox"/> Judson R. Roberts, D.D.S. | <input type="checkbox"/> Robin H. Berrin, D.D.S. | <input type="checkbox"/> Judith V. Lane, D.D.S. |
| <input type="checkbox"/> Robert W. Pretel, D.D.S., M.S.D. | <input type="checkbox"/> P. Paul Towfighi, D.D.S., M.S. | <input type="checkbox"/> P. Kevin Chen, D.M.D., M.S. |
| <input type="checkbox"/> Rosemary Wu, D.M.D., M.S. | | <input type="checkbox"/> David S. Amid, D.D.S. |

Appointment Policy

Our policy requires that all appointments be confirmed 48 hours in advance. In the event we are unable to reach you to confirm your appointments or we do not hear back from you at least 24 hours prior to your appointment time, it may be necessary for us to offer your appointment to another patient. If you cancel or fail your scheduled appointment, we may be unable to reschedule you, or may require you to prepay your estimated portion in full.

Revised 02/08

PATIENT COPY

Referral CPG034