The Beverly Hills Center
FOR ADVANCED DENTAL IMPLANTS & PERIODONTOLOGY

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PATIENT INFORMATION:

Today's Date_____

First Name_____ Last Name_____ Date of Birth_____

Parent / Guardian Name_____

Contact Telephone_____ Contact E-Mail Address_____

Does the patient require antibiotics prior to dental treatment? ❑ Yes ❑ No

REFERRING DOCTOR'S INFORMATION:

Referred By_____ Telephone_____

E-Mail Address_____

REFERRED FOR THE FOLLOWING:

❑ Complete Periodontal Evaluation: ❑ Early ❑ Moderate ❑ Advanced

❑ Implants
❑ Gingival Recession
❑ Graft for Root Coverage
❑ Crown Lengthening
Teeth #_____

❑ Guided Tissue Regeneration
Teeth #_____
❑ Gingival Contouring for Cosmetics
Teeth #_____
❑ Ridge Augmentation

❑ Extraction
❑ Scaling and Root Planing
❑ Periodontal Maintenance
❑ Other_____

RADIOGRAPHS OR CLINICAL PHOTOS:

❑ Being Mailed
❑ Given To Patient
❑ Please Take
❑ No X–Ray

TO ATTACH X-RAY(S) TO THIS REFERRAL FORM PLEASE SUBMIT THE FORM ABOVE OR BELOW.

AFTER THE FORM IS SUBMITTED YOU WILL THEN HAVE THE OPTION TO UPLOAD X-RAYS THAT WILL BE ATTACHED TO THIS REFERRAL FORM.

If X-Rays are attached, what date were they taken_____

PERIODONTAL TREATMENT COMPLETED IN YOUR OFFICE:

❑ Plaque Control Instruction
❑ Prophylaxis and Gross Scaling
❑ Root Planing
❑ Periodontal Maintenance Therapy

POSSIBLE EXTRACTIONS:

Have you advised the patient of the possibility of extraction? If so, which tooth number(s)_____

IS THERE ANY RESTORATIVE DENTISTRY THAT NEEDS TO BE COMPLETED:

COMMENTS:

JEAN-JACQUES ELBAZ, D.D.S., M.S.

Diplomate of the American
Boards of Periodontology
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Practice Limited to Periodontics
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