



Dr. Marie McKenzie-Tola

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Patient Referral - Periodontal & Dental Implants

PLEASE BRING THIS FORM TO YOUR APPOINTMENT

Introducing: _____ Appointment Date & Time: _____

This patient is being referred for evaluation of the following symptoms:

Tooth Number or Area For Consideration:

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Upper Right Lower Right Upper Left Upper Left

Comments:

Please call me before proceeding with treatment.

I have sent radiographs for your evaluation.

Please email radiographs to: hopewellfrontdesk@gmail.com

Referring Doctor: _____

Referring Date: _____

Referring Practice Name: _____

Referring Phone#: _____