GREAT PLAINS
PERIODONTICS & IMPLANT DENTISTRY

PATIENT REFERRAL SLIP

DATE:

TO: Dr. Robert J Moeller

LOCATION: 1011 E Prescott, Salina, KS 67401

PATIENT INFORMATION

NAME: _____ CELL PHONE:_____

ADDRESS:_____ HOME PHONE:_____

_____ DOB:_____

EMAIL: _____

PLEASE CIRCLE ONE

Patient is Scheduled Please call Patient to Schedule Patient will call to Schedule

FOR TREATMENT OF:

_____

_____

Date of BWX:

Date of PA's:

Date of FMX:

Date of PANO:

Date of CBCT:

PLEASE SEND ALL PATIENT X-RAYS WITH REFERRAL LETTER, THANK YOU

RESTORATIVE TREATMENT PLAN:

ANY PREVIOUS PERIODONTAL THERAPY: **NO** **YES on** _____

(date)

NOTE: All payments are due at the time of service. Dr. Moeller's office WILL submit to most dental insurance companies for their convienence.

NEW PATIENT FORMS can be filled out at www.salinaperio.com before their scheduled appointment.

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