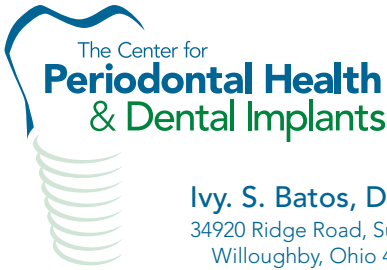
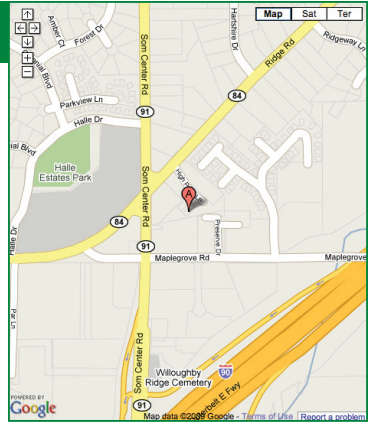


# PATIENT REFERRAL FORM



The Center for  
**Periodontal Health  
& Dental Implants**

Ivy. S. Batos, D.M.D.  
34920 Ridge Road, Suite 200  
Willoughby, Ohio 44094  
**(440) 951-1008**



## Patient Information

Name \_\_\_\_\_

Date \_\_\_\_\_

Referring Doctor \_\_\_\_\_

Radiographs Avail. \_\_\_\_\_ None \_\_\_\_\_ BW \_\_\_\_\_ PANO \_\_\_\_\_ Full Mouth \_\_\_\_\_ CT Scan

## Reason for Referral

\_\_\_\_\_ Periodontal Exam (areas of concern) \_\_\_\_\_

\_\_\_\_\_ Implant(s) # \_\_\_\_\_

\_\_\_\_\_ Tissue Graft # \_\_\_\_\_

\_\_\_\_\_ Crown Lengthening # \_\_\_\_\_

\_\_\_\_\_ Ridge Augmentation # \_\_\_\_\_

\_\_\_\_\_ Biopsy \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

## Comments

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**Ivy S. Batos, D.M.D. | Practice Limited to Periodontics, Implants, TMJ.**

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**REFERRING PRACTICES: PLEASE PRINT AND DUPLICATE FOR YOUR RECORDS.**