



Irving Horowitz, D.M.D., P.A.

Practice Limited to Periodontics • Implants
NJ Specialty Permit #2869

Route 206 • P.O. Box 334
Rocky Hill, NJ 08553

Phone: 609-921-1940
Fax: 609-921-1028

Patient: _____ Date: _____

REFERRAL INFORMATION

APPOINTMENT:

- Please call patient for appointment. Patient's phone: _____
- Patient will call your office for appointment.
- If the patient does not call within 14 days, please call him/her. Yes No

I AM REFERRING THIS PATIENT FOR:

- Complete Periodontal Evaluation & Treatment
- Isolated Periodontal Eval. & Treatment _____
- Crown Lengthening Procedure _____
- Recession & Grafting _____
- Ridge Augmentation _____
- G T R & Bone Grafting _____
- Implant Consultation _____
- Sinus Lift/Graft
- Other: _____

RADIOGRAPHS:

- Are enclosed. Last Full Series Taken On: _____
- Are accompanying patient.
- Are being forwarded to you. FMX ____# PA ____# Other _____

PERIODONTAL TREATMENT COMPLETED IN OUR OFFICE:

- Plaque Control & Oral Hygiene Instruction
- Root Planing and Scaling (Areas: _____) (Date: _____)

PREMEDICATION OR SPECIAL MEDICAL CONSIDERATION: Yes No

FUTURE RESTORATIVE NEEDS

- Crowns Bridges Remove Prosthesis Caries Other

CASE PLANNING

- Please call BEFORE examination. Please call AFTER examination but before consult.

COMMENTS

Doctor: _____

PLACE
STAMP
HERE

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FOLD AND TAPE CLOSED