ROBERT M. BENEDON, D.M.D.

PERIODONTICS & DENTAL IMPLANTS

SOCIETY HILL OFFICE PARK
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TELEPHONE 856/424-0580
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NJ SPECIALTY PERMIT # 3260
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REFERRAL FORM

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____ CELL PHONE _____

❑ PLEASE PROVIDE COMPREHENSIVE EVALUATION AND TREATMENT AS INDICATED.

❑ PLEASE PROVIDE PERIODONTAL EVALUATION LIMITED TO _____

❑ PLEASE EVALUATE FOR CROWN LENGTHENING TOOTH # _____

❑ PLEASE EVALUATE FOR SIGNIFICANCE OF GINGIVAL RECESSION, TOOTH # _____

❑ PLEASE EVALUATE FOR DENTAL IMPLANTS, TOOTH # _____

❑ PLEASE EVALUATE FOR LANAP (LASER ASSISTED NEW ATTACHMENT PROCEDURE) _____

❑ PLEASE EVALUATE FOR LAPIP (LASER ASSITED PERI-IMPLANTITIS PROCEDURE) _____

❑ PLEASE EVALUATE FOR PST (PIN HOLE SURGICAL TECHNIQUE) TOOTH/TEETH # _____

❑ OTHER _____

RECENT FULL MOUTH X-RAYS ARE / ARE NOT AVAILABLE. DATE OF X-RAYS _____

REFERRED BY _____ DATE _____

PLEASE GIVE COPY TO PATIENT AND MAIL COPY TO OFFICE AT ABOVE ADDRESS