Associates in PIE
Periodontics, Implantology & Endodontics

Periodontists	**Endodontists**
☐ Michael Goodwin	☐ Chad Green
☐ Fred Silva	☐ Susana Bruce
	☐ Jenny He

REFERRAL FORM

Flower Mound Fax: (972) 538-3771   Denton Fax: (940) 566-7004   McKinney Fax: (972) 547-1701

Referred by: ______________________________________ Date: __________________________________

Patient's Name: ________________________ Cell: (______) _____________ Hm. Ph: (______) ______________

Appointment Date: ____________________ Time: ___________ ☐ am / ☐ pm D.O.B ___________________

OFFICE PREFERENCE

O FLOWER MOUND: 1005 Long Prairie Road, Suite 100   Flower Mound, TX 75022   **Phone**: 972-538-3700

O DENTON: 3000 Wind River Lane, Suite 100   Denton, TX 76210   **Phone**: 940-566-7070

O MCKINNEY: 1750 N. Stonebridge Drive, Suite 103   McKinney, TX 75071   **Phone**: 972-547-4141

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

PERIODONTIC REFERRAL

O Dental Implants (Single / Multiple / All-On-X)

O Periodontal Disease

O Gum Graft

O Extraction and Bone Graft

O Ridge Augmentation / Sinus Lift

O Crown Lengthening (Functional / Cosmetic)

O Other: ______________________________

RADIOGRAPHS

O Radiographs (Email to office@piedental.com)
Type: __________ Date: _________

O Please take new radiographs

ENDODONTIC REFERRAL

O Endodontic evaluation

O Root Canal Treatment (RCT)

O Root Canal Re-Treatment

O Apicoectomy

O Other: _______________________________
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O Tooth presents with:

- O Pain to: cold / hot / biting
- O Swelling
- O History of crack/fracture
- O Vague unlocalized pain

INSURANCE INFORMATION

Policy Holder: ______________________ Company: ______________________ Phone #: _______________

Employer: ____________________ ID #: ________________ Group #: _____________ D.O.B. ___________

COMMENTS

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