



BOARD CERTIFIED PERIODONTISTS

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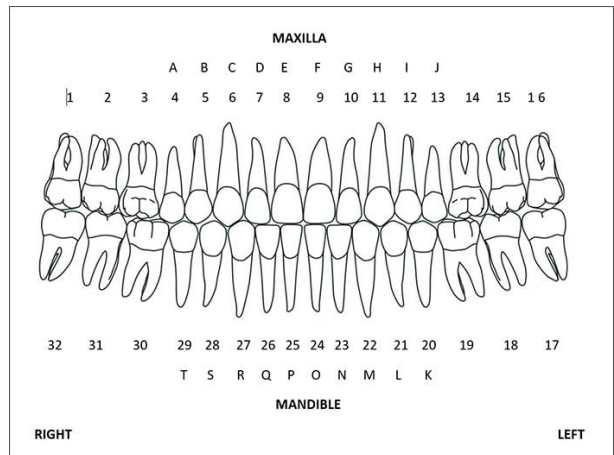
Date: _____

Patient Name: _____

Patient Phone Number: _____

Reason for Referral:

- Full Mouth Examination _____
- Localized _____
- Implant _____
- Extractions _____
- Recession _____
- Crown Lengthening _____
- Ortho-Perio _____
- Other _____



History of Periodontal Therapy:

Restorative Considerations:

Radiographs: Full Mouth Panoramic Bite Wings Periapical CBCT

Additional Comments Relevant to this referral:

Referring Doctor: _____

WAUKESHA
 2316 N. GRANDVIEW BLVD.
 WAUKESHA, WI 53188
 262-547-1877

MUKWONAGO
 400 BAY VIEW RD STE K
 MUKWONAGO, WI 53149
 262-363-1933

Please send or fax referral to: 262-521-3476 **OR** office@lakecountryperio.com