New Hampshire Center for Periodontics

John R. Herrin, DDS, MS

Date of Referral: _____

Patients Name: _____ **Phone #**: _____

Referral From: _____ □ Please contact Patient
□ Patient will contact you

□ Please call me prior to seeing patient _____

□ Please contact me after patient is seen _____

Area(s) of Concern: _____
_____
_____
_____

Comprehensive Examination Completed:	Y / N / NA
If yes, Please enclose/attach Treatment plan:	Y / N / NA
I have developed a comprehensive treatment plan:	Y / N / NA
Let's develop a comprehensive treatment plan together:	Y / N / NA
Examination findings enclosed:	Y/ N / NA

Most Recent Supportive visit:_____

Occlusal Orthotic Appliance Created / Worn: Y / N / NA

Most recent radiographs: It helps us better serve your patient if we have current radiographs to view. We prefer to have a full series of radiographs within the last 3 years and bite wings within the year.

FMS _____ ***Bite Wings***_____ ***Other***_____

□ Radiographs attached □ Patient will bring radiographs □ Please take radiographs

Other information you would like to share with us to better serve your patient:
_____
_____
_____
_____

((Driving directions link from website))

We look forward to caring for your patient and helping them achieve dental health.

Helping create long, healthy lives one confident, beautiful smile at a time.

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www.nhcenterforperio.com