ORANGE PERIODONTICS
AND DENTAL IMPLANTOLOGY

Cliff Lee DMD MS, Sepi Lee DDS MS

Date: _____

PATIENT INFORMATION

Name: _____ DOB: _____

Email: _____ Phone: _____

REFERRING OFFICE

Doctor: _____

Email: _____ Phone: _____

CLINICAL DETAILS

I am referring the patient for:

☐ Comprehensive Eval ☐ Limited Eval ☐ Emergency

This patient may need:

☐ Periodontal disease treatment ☐ Extractions ☐ Implants

☐ Crown lengthening ☐ Gum grafting ☐ Bone grafting

Patient radiographs:

☐ Sent to contact@ocperio.com ☐ With patient ☐ None available

Comments:

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