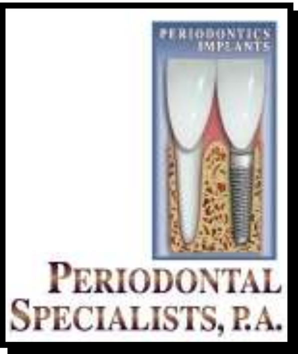

REFERRAL FORM

Melissa A. Combs, D.D.S.
Jonathan S. Thomas, D.D.S.
Daniel J. Thomas, D.D.S., M.S.
* Diplomates, American Board of Periodontology

Referring Doctor: ______________________ Date: ______________

I am referring: ______________________ H. Phone: ______________

W. Phone: ______________

1	2	3	4/A	5/B	6/C	7/D	8/E	9/F	10/G	11/H	12/I	13/J	14	15	16
32	31	30	29/T	28/S	27/R	26/Q	25/P	24/O	23/N	22/M	21/L	20/K	19	18	17

- ❑ Complete periodontal exam and consultation
- ❑ Correction of an isolated problem ONLY please: ______________
- ❑ Esthetic Crown Lengthening for gummy smile: ______________
- ❑ Esthetic Crown Lengthening to even smile: ______________
- ❑ Crown Lengthening for restorative care: ______________
- ❑ Root Coverage Grafting: ______________
- ❑ Soft Tissue Grafting for mucogingival involvement: ______________
- ❑ Ridge Augmentation (soft or hard tissue) in pontic area: ______________
- ❑ Hemisection: ______________
- ❑ Root amputation: ______________
- ❑ Frenectomy (maxillary/mandibular/lingual): ______________
- ❑ Orthodontic Exposure of impacted tooth: ______________
- ❑ Soft Tissue Biopsy: ______________
- ❑ Implants: ______________
- ❑ Other: ______________

Our Office:

- ❑ Will send a recent full mouth series
- ❑ Will send a recent panoramic x-ray
- ❑ Will send current vertical bitewings
- ❑ Would like your office to take the necessary x-rays

The restorative plan that I am considering includes:

____

____

Comments: ______________________________

____

❑ 11401 Nall Avenue.
Leawood, KS 66211

❑ 9321 N Oak Trafficway
Kansas City, MO 64155

❑ 411 Nichols Rd., Ste. 236
Kansas City, MO 64112

❑ 3355 NE Ralph Powell Rd.
Lee's Summit, MO 64064

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