# Amir D. Hosseini, D.D.S.

**Aesthetic Periodontal & Implant Specialists**

**Phone # (210) 614-4700 Fax #: (210) 545-1884**


**FAX COVER SHEET NOT REQUIRED**

**Fax or Email: aestheticperiodontist@gmail.com**

## Referral Form

Date: _____

**Referring D.D.S**:_____ **Dental Office Name/Location** (if applicable):_____

Patient Name: _____ DOB:_____ SS#:_____

Address: _____ City/State/Zip:_____

Home#:_____ Work#:_____ Cell#:_____ Text:Yes/No E-mail:_____

Insured's Name: _____DOB:_____ SS#/ID#:_____

Insurance Name: _____ Phone#:_____

Employer: _____ Group#:_____

**REASON FOR REFERRAL: □ Implant □ Periodontal**

Please specify areas so that we can best prepare for you patient's consultation.

□ Periodontitis (Slight, Moderate, Severe) □ Isolated Procedure #_____

□ Recession #_____ □ Implant #_____

□ Impressions Taken_____ □ Consultation_____

**Additional Comments:**_____

_____

_____

_____

_____

**PLEASE SEND: □Treatment Plan □ Probe Chart □ FMX Date Taken_____**

**□ BWX □ PAX □PAN □ Diagnostic Models □ Have your office take necessary radiographs**

Please indicate the general dentistry you have recommended to our mutual patient. This information will be used to support the patient's completion of definitive dentistry in your office. (Please list appropriate teeth.)

**RECOMMENDED TREATMENT PLAN MAY INCLUDE:**

Operative #_____ Endodontics #_____

Crowns #_____ Occlusal Therapy #_____

Fixed Bridge #_____ Extractions #_____

Removable Partial Denture_____ Questionable Prognosis #_____

Last recall/hygiene date_____ Next recall/hygiene date_____

Next dental appointment_____

**APPOINTMENT STATUS:**

□ An appointment was made by our office: Date:_____ Time:_____

**Office Locations**

**Pleasanton Location**:1301 W. Goodwin St; Pleasanton, Texas 78064

**Westwood Center Location**: 11019 Culebra Rd. Ste. 162 San Antonio, Texas 78253

**Stone Oak Location**: 1130 E. Sonterra Ste 120 San Antonio, Texas 78258

**Please Mail All Correspondence to Our Stone Oak Office**