

512 Smiles

M.D. REFERRAL FORM

DR. PRIYA MEGHPARA & DR. MARK PEPPARD

Referring Doctor _____

Referring Office _____

Office Number _____

Office E-Mail _____

Patient Name _____

Phone Number _____

Date of Birth _____

Reason For Referral _____

.....

Referring Reason:

☐ For Comprehensive Dental Care

☐ TMJ / Facial Pain

☐ Airway

☐ Other: _____

Patient Information:

☐ History of Bisphosphonate Use?

☐ History of Head and Neck Radiation?

☐ History of Surgery?

☐ History of Joint Replacement, Stroke and/or Heart Attack?

☐ Currently Taking a Blood Thinner?

Checklist:

☐ Complete Medical History

☐ Referral from provider with detailed information regarding their assesement and reason for referral

☐ Pre-Medication Requirements? YES / NO.

**If yes, please provide initial prescription

☐ Can patient have imaging? Circle: YES / NO 2D / 3D CBCT

**If no, please provide recent history of previous imaging.

☐ Provide all recent dental, airway and/or TMJ imaging

Please provide ALL pertinent details below. Use attachments if necessary.

M.D. Signature: _____

DATE: _____

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DR. PRIYA MEGHPARA & DR. MARK PEPPARD

Referring Doctor _____

Referring Office _____

Office Number _____

Office E-Mail _____

Patient Name _____

Phone Number _____

Date of Birth _____

Reason For Referral _____

..... Please Evaluate:

☐ For Comprehensive Dental Care

☐ TMJ / Facial Pain

☐ Airway

☐ Other: _____

Patient Information:

☐ History of Bisphosphonate Use?

☐ History of Head and Neck Radiation?

☐ History of Surgery?

☐ History of Joint Replacement, Stroke and/or Heart Attack?

☐ Currently Taking a Blood Thinner?

Include all pertinent imaging including 3D-CBCT and/or Panoramic X-Ray.

Please provide ALL pertinent details below. Use attachments if necessary.

SIGNATURE: _____

DATE: _____