



# SOUTHERN ROOTS

PERIODONTICS AND DENTAL IMPLANT SPECIALISTS

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DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

PATIENT PHONE #: \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_

May we contact your patient to schedule an initial appointment?  Yes  No

## REASON FOR REFERRAL

Periodontal Disease

Implant

Biopsy

Tissue Grafting

CBCT Only

Other/Notes

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Cincinnati Magazine

**TOP DENTISTS**



### Our Locations

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