

**Gregory Langston, DMD, MSD**  
**Contemporary Periodontics & Implant Dentistry**  
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**DENTAL IMAGING REFERRAL FORM**

**REFERRING DENTIST INFORMATION**

Full Name: \_\_\_\_\_ Date Referred: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Patient's Address: \_\_\_\_\_  
Home Tel: \_\_\_\_\_ Mobile Tel: \_\_\_\_\_

(Check all that apply)

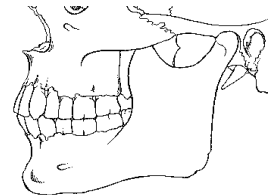
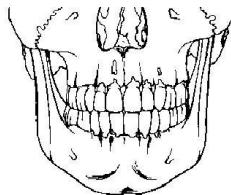
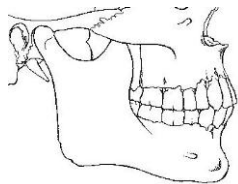
**REASON FOR REFERRAL:**

TMJ Assessment     Sinus Assessment     Airway Assessment  
 Endodontic Assessment     Implant Assessment     Implant Surgical Placement Only  
 Implant Surgical Placement & Restoration     Implant Problems & Diagnosis  
 Augmentation & Surgical Placement     Entire Maxillofacial Region     Orthodontic  
 Oral Pathology     Impaction    Other: \_\_\_\_\_  
  
 Cone Beam CT     Digital Panoramic     Cephalometric

**Region(s) of Interest:**

\_\_\_\_\_  
\_\_\_\_\_

**Circle Area:**



**FORMAT DATA DELIVERY OPTIONS FOR SCAN:**

E-MAIL  
 PRINTS  
 DUPLICATE CD NEEDED  
 Other: \_\_\_\_\_

Please send by **FAX** to 727-578-8500 or

**SCAN** and **EMAIL**, RE: Patient Referrals to: [Glangston@ContemporaryPerio.com](mailto:Glangston@ContemporaryPerio.com)

**ONCE COMPLETED HAVE PATIENT CALL TO SCHEDULE AN APPOINTMENT**