SAMANTHA ROBLES D.M.D.,M.S.D.,PA

LASER PERIODONTICS & IMPLANT THERAPY

4301 Ben Franklin Blvd • Suite 101 • Durham, North Carolina 27704

Phone: 919.383.6611 • **Fax:** 919.383.6612

Email: office@drsamperio.com • **Web:** www.drsamperio.com

Referred by Dr.____________________ **Referral Date:**__________

Patient Name:______________________________

Phone (Cell/Home):__________________________

Patient Email:______________________________

Reason for Referral: i.e. Complete Exam, Gingival Recession, Implant Evaluation, Extractions, Bone Grafting, Crown Lengthening (Clinical or Esthetic), Periodontal Therapy

____

____

Pertinent Information: Was initial therapy completed; what is the restorative treatment plan that would impact the perio tx?

____

____

Medical Consideration: Antibiotic premed? Blood thinners? History of medications for osteoporosis? (Fosamax, Reclast, Prolia, etc.)

____

____

Email all radiographs taken within the past 12 months to: office@drsamperio.com

– Se Habla Espanol –