

BIRMINGHAM PERIODONTAL and IMPLANT CENTRE

Dr B S Ubhi BDS MDentSci MRD RCS (Eng)

Date

Referring Dentist

Name

Practice Address

Tel

Fax

E-mail

Patient Details

Name: Mr/Mrs/Ms

M/F

Address

Tel:Home

Work

Other

Please evaluate the following:

Full mouth examination

Specific Areas

Crown Lengthening

Tissue Graft

Other

Additional information.

Radiographs:

Sending with patient

Please take

Signed:_____

Date:_____