PERIODONTAL REFERRAL DIRECTIVE

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❑ ***Dr. D. J. ZEITER***
❑ ***Dr. T. C. JACKSON***
❑ ***Dr. D. S. WEITZ***

Referred by Dr. _____ **Date:** _____

Patient's Name: _____

Address: _____

Phone: Res: _____ **Cell:** _____

Email Address: _____

Is this urgent? ❑ Yes ❑ No **Is antibiotic prophylactic coverage required?** ❑ Yes ❑ No

Radiographs available _____ Will be mailed/emailed _____ Patient will bring _____

Reason for Referral:

_____

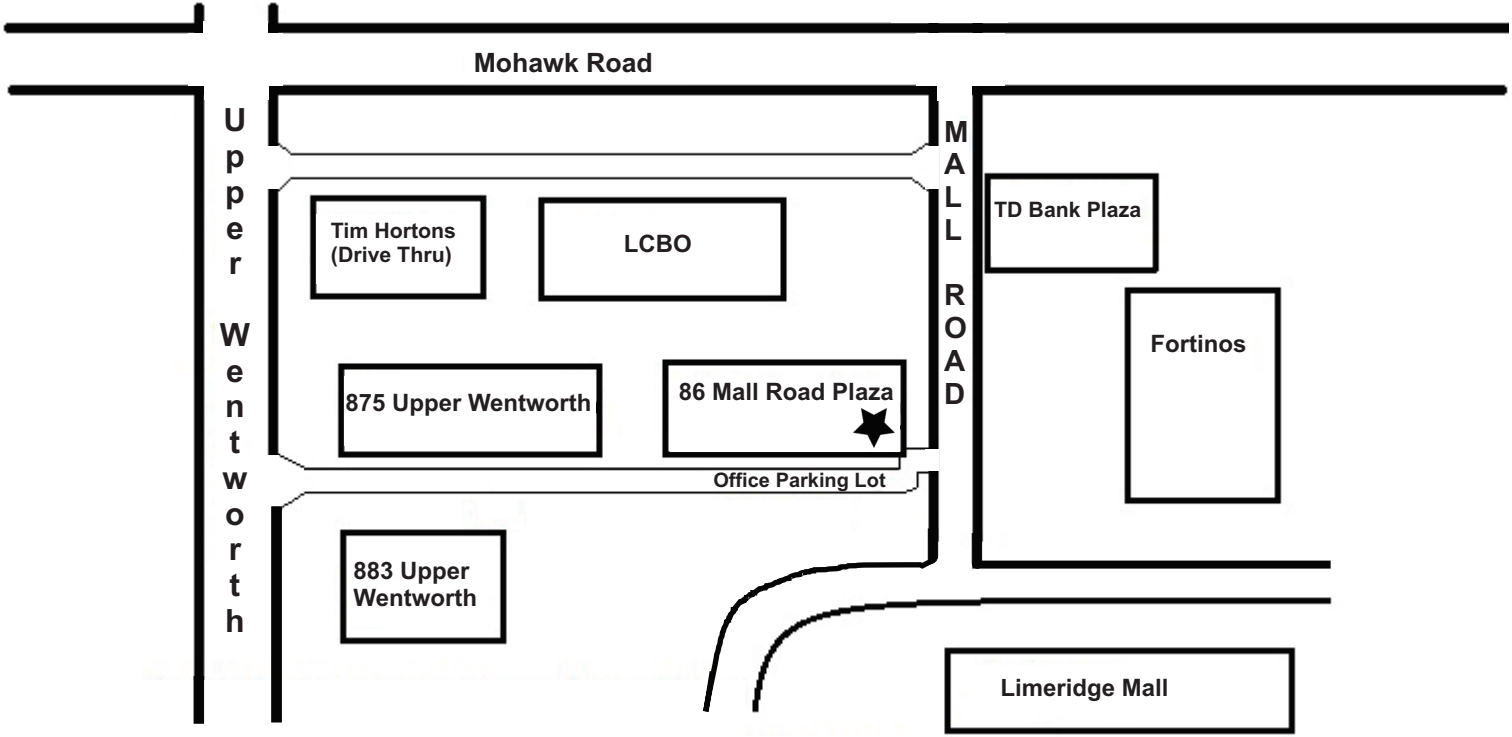
_____

_____

_____

_____

Appointment scheduled for: _____ Time: _____



Our office does not accept assignment of benefits from your insurance company.
We accept Visa, MasterCard, American Express, Debit, cash or cheque upon completion of your appointment.
We require 48 hours notice (2 business days) to reschedule appointments.
We look forward to meeting you.