REFERRAL FAX

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P: 512-454-6861 · F: 512-454-4350

No Cover Sheet Required

Faxed: ❑Y ❑ N; Date Faxed: _____

From: _____

To: Dr. David M. Ferguson, DDS, MSD
Fax: (512) 454-4350 _____

Patient Name: _____
Insurance: ❑Y ❑ N
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Requires Premedication: ❑Y ❑ N Allergic to Penicillin: ❑Y ❑ N

Reason for Referral:

❑ Periodontal Evaluation # _____ ❑ Root Amputation # _____
❑ Crown Lengthening # _____ ❑ Implants # _____
❑ Gingival Recession # _____ ❑ Other _____

Radiographs:

❑ Take double FMX & send me a copy ❑ Patient to bring FMX
❑ I am mailing FMX ❑ Please return my FMX

Comments: _____

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