DENTAL SPECIALISTS GROUP
YOUR SMILE OUR SPECIALTY

Dr. PRAGTIPAL SAINI
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Diplomate of American Board
of Periodontology

Date: .....

Patient: ..... M☐ F☐ Age .....

Referred by: ..... Phone: .....
(DOCTOR)

Patient Telephone# H ..... W ..... Cell .....

(Significant Medical History/Medications) .....

..... (please forward all records/radiographs/correspondence)

Please indicate the reason for referral

Specific area Exam .....

Peri-Implantitis .....

Gum Recession/ Grafting .....

Bone graft/Sinus augmentation for implant placement .....

Dental Implants .....

Radiographs

1.PERIAPICALS Y☐ N☐ (date) ..... (PLEASE CIRCLE) 87654321 12345678
87654321 12345678

2.PANOREX Y☐ N☐ (date) .....

3.BITE WINGS Y☐ N☐ (date) .....

Additional Comments

PLEASE EMAIL COMPLETED FORM TO INFO@DSGSMILE.CA
(416) 477-6453 | 6175 Hwy 7, Unit 1A, Woodbridge, Ontario L4H 0P6